Commission of Inquiry Into Matters
Relating to the Death of Neil Stonechild

Written Submission

on behalf of the
Saskatoon Police Service

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Part I
Introduction

1. A police service, and our criminal justice system, need the confidence of the public in order to function properly and efficiently. The Saskatoon Police Service acknowledges that its investigation of the death of Neil Stonechild and its handling of the concerns of the family of Neil Stonechild should have been better.

2. The detailed examination by this Commission of the conduct of the Saskatoon Police Service investigation of the death of Neil Stonechild has been very difficult for the Saskatoon Police Service and its members. But the Saskatoon Police Service agrees that examination was necessary, and believes that it has already been beneficial to it, and to the community. Mistakes were made. The Saskatoon Police Service has learned from them and has already made some changes to its policies and procedures to try to prevent the happening of the same in the future, and looks forward to this Commission's report and recommendations as to what additional matters it can and should do to improve itself and to provide better service to this community. The Saskatoon Police Service is confident that the report and recommendations of this Commission will go a long way in helping the Saskatoon Police Service improve the services it offers to the citizens of this community.

Part II
Submission

3. There are four areas that the Saskatoon Police Service wishes to address:

   (a) Brief comments regarding the original Saskatoon Police Service investigation;

   (b) Brief discussion as to the evidence of several witnesses, and in particular, Jason Roy and Dr. Emma Lew;

   (c) Concerns raised over the Saskatoon Police Service Issue Team; and

   (d) Improvements and changes made by the Saskatoon Police Service since 1990, and recommendations that the Saskatoon Police Service submits that the Commissioner may wish to consider.

(a) Brief Comments Regarding the Original Saskatoon Police Service Investigation

4. In his evidence, Deputy Chief Dan Wiks, on behalf of the Saskatoon Police Service, acknowledged that the investigation by the Saskatoon Police Service of the death of Neil Stonechild was inadequate. During his testimony on January 8 and 9, 2004, Deputy Chief Wiks reviewed the investigation and pointed out those parts that, in his view, had been conducted properly, and those that had not.

5. In summary, Deputy Chief Wiks testified that, in his view, it would likely have been very helpful had either a Morality or a Major Crime Investigator been directed to attend at the scene. He also testified that there should have been a better search of the scene, especially relating to the missing shoe of Neil Stonechild. There should have been better follow-up with a number of witnesses and certain leads. Following from that there should have been an explanation of how some of the conclusions were arrived at. (For example, the elimination of “the Pratts” as suspects.)

6. It is not clear exactly what happened, but there should have been more consideration given to the request of Sergeant Keith Jarvis to have the file transferred to Major Crime. Further, it is common knowledge that the early days of an investigation are the most important, and as such the file ought not to have been permitted to sit uninvestigated for several days while Sergeant Jarvis was on days off. Finally, it appears that the file had been prematurely closed, and that little or no review of that decision was in fact made.

7. More comments will be made about policy and procedure in the section entitled “Improvements and Changes made by the Saskatoon Police Service since 1990, and Recommendations that the Saskatoon Police Service Submits that the Commissioner May Wish to Consider”

(b) **Brief Discussion as to the Evidence of Several Witnesses, and in particular, Jason Roy and Dr. Emma Lew**

8. The first term of reference given to this Commission was to inquire into any and all aspects of the circumstances that resulted in the death of Neil Stonechild. To that end, this Commission examined those circumstances in detail hearing many days of testimony from numerous witnesses, who were examined and cross-examined. The Commission also had the benefit of the extensive RCMP investigation prior to the Commission, and further investigations conducted by the Commission through its counsel prior to and during the hearings.

9. Numerous theories were propounded and possibilities were raised. Unfortunately, it seems to the Saskatoon Police Service, despite all these efforts, no clear picture emerged as to exactly what happened after Jason Roy and Neil Stonechild parted.

10. The Saskatoon Police Service will leave detailed discussion and arguments about evidence and its meaning to other parties to this Commission, but does wish to comment briefly on some aspects of several witnesses, mostly Jason Roy and Dr. Lew.

11. The evidence of Jason Roy is important because he was the last known person to have contact with Neil Stonechild. The Saskatoon Police Service submits that this Commission should consider the following points:

- his evidence at the time by means of his written statement to Sergeant Jarvis was not the same as the evidence he ultimately gave to this Commission in significant respects.

- there is a significant possibility that Jason Roy was the victim of the phenomena Dr. Steven Richardson described as “filling in”. As well, Dr. John Yuille testified that memory does not generally improve over time, and one should be suspicious of memory that does improve over time, absent some explanation.

- as noted, Jason Roy’s evidence changed significantly from 1990 to that given to this Commission. But an examination of what he said to other witnesses over time indicates that his evidence seems to have changed “incrementally”. This was described in the application of the Saskatoon Police Service to call Dr. Jim Arnold, which application was heard on January 9. Those points will not be repeated here since they appear in the transcript.

- before this Commission, Jason Roy testified that he saw Neil Stonechild in the back of a Saskatoon Police Service car in handcuffs with blood running down his face and a gash on his nose. But, Dr. Lew testified that in her opinion, based upon an examination of close-up photographs prepared by the University of Saskatchewan

Anatomy Department[1], that the injuries to Neil Stonechild's nose were caused perimortem, that is at or about the time of his death, and therefore it would have been impossible for Jason Roy to actually have seen what he appears to believe he saw. Furthermore, there was no evidence to substantiate the significant bleeding Jason Roy described.

- as to the handcuffs, it is submitted that the evidence of Gary Robertson was completely refuted by Dr. Lew's evidence. Her examination of the marks on Neil Stonechild's right hand, as depicted in the enlarged photographs prepared by the University of Saskatchewan Anatomy Department, led to her conclusion that the marks were not consistent at all with handcuffs, but are consistent with post mortem clothing marks. In fact, Dr. Lew testified that there is visible within the marks themselves a pattern consistent with the weave of cloth, and not the smooth metal of handcuffs. Further, the mark is not consistent with handcuff marks in terms of placement on the hand and the fact that in the area at the base of the thumb there is an indent on either side of a highpoint at the base of the thumb, but no mark whatsoever on that highpoint. Thus, while the evidence of Gary Robertson at one time appeared important, it is apparent that his conclusion or assumption that the injuries to Neil Stonechild's nose or the marks on his wrist were caused by handcuffs is simply wrong.

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[1] Unfortunately Dr. Dowling, Dr. Adolph and Dr. Fern did not have the benefit of seeing the close-up photographs prepared by the University of Saskatchewan Anatomy Department at the time they testified because no one appears to have thought of having such prepared until suggested by Dr. Lew, Dr. Rao and Dr. Matshes in November of 2003.

(c) Concerns Raised over the Saskatoon Police Service Issue Team

12. Over the course of the Inquiry, concerns were expressed regarding the Saskatoon Police Service Issue Team and the fact that Saskatoon Police Service did consult with experts about some aspects of the Neil Stonechild matter.

13. As Deputy Chief Wiks testified, the Saskatoon Police Service had never been through an Inquiry of this sort before. The Saskatoon Police Service therefore created a body which became known as the "Issue Team". Its primary functions were to identify, locate and provide to Commission Counsel any information and documentation required for this Commission, to do prepatory work that the Saskatoon Police Service needed in order to ready itself for the Commission hearings, to deal with security and safety matters for this Commission in conjunction with the RCMP and Commission Counsel and to develop communication plans both internally and externally. In that regard, it established liaison mechanisms with the RCMP and the Saskatoon City Police Association with respect to its members. As part of its functions it attempted to identify any issues that might arise or that should be raised in relation to this Commission, and it did also act as a "sounding board" in respect to various matters.

14. As a result of various ideas raised by the Issue Team, and various requests made by Commission Counsel, the Saskatoon Police Service generated a large number of reports, which were disclosed to Commission Counsel, and many of which have been marked as exhibits in these proceedings.

15. The entire minutes of the Issue Team (with certain security and solicitor-client issues excluded) were provided to Commission Counsel at his request, without any objection, and made an exhibit in this proceeding.

16. As is apparent from the minutes of the Issue Team, these were not formal minutes in the sense that they documented formal resolutions, etc., but simply were notes about all the matters, speculation, possibilities, thoughts, etc. discussed by the Issue Team.

17. From previous experience when “high profile” cases are before the courts, the Saskatoon Police Service was aware that it would likely receive “tips” from the public as the Inquiry proceeded. Accordingly, it set up a tip line. **All** tips received were passed on to the RCMP and/or Commission Counsel to do with as they saw fit - **none** were investigated by the Saskatoon Police Service.

18. In relation to Saskatoon Police Service employees, the Issue Team did discuss modes of communication with Saskatoon Police Service members to make sure that members who, obviously, are and were keenly aware and interested in the issues being dealt with by this Inquiry, could be kept informed. It also dealt with and discussed issues with respect to Constables Larry Hartwig and Brad Senger, given their particular involvement.

19. The existence of the Issue Team was not hidden. An examination of the minutes demonstrate that it was not an investigative body. It related to various brainstorming and preparation issues to try and figure out what kinds of information the Saskatoon Police Service had or could acquire from its records which would assist the Commission and what the

Saskatoon Police Service might need to do to prepare for the Inquiry. The fact that the minutes are so complete and document **all** matters discussed by the Issue Team indicate that there was absolutely no intention whatsoever to interfere with any part of the RCMP investigation. Nor did that happen in fact. In fact the opposite is true. The Issue Team was there to and, it is submitted, did assist in the Inquiry in any way it could.

20. As a party granted standing to the Commission, the Saskatoon Police Service received in June of 2003 disclosure from Commission Counsel. Included in that were the Gary Robertson photogrammetric materials. Gary Robertson's materials, at that time, appeared very important. As Deputy Chief Wiks testified, he had never heard of photogrammetry and needed to know what it was and how it worked, etc. The Saskatoon Police Service also needed to know whether or not this was a valid application of the procedure, and whether the results were trustworthy, in general, and specifically in this case.

21. Deputy Chief Wiks met with RCMP officials in August of 2003 and expressed certain concerns he had, as a fellow police officer, in terms of the apparent conclusions of Gary Robertson. The RCMP were not able to answer those concerns, and Deputy Chief Wiks advised officials of the RCMP that the Saskatoon Police Service was intending to consult Dr. B. McGee, a forensic pathologist (see evidence of Chief Superintendent Darrell McFadyen). The RCMP gave him their "blessing", and the consultation proceeded (transcript pages 6113 and 6114).

22. It is important to note that the Saskatoon Police Service had duly applied to this Commission for permission to consult with Dr. McGee, and as part

of that application agreed that all information from Dr. McGee would be made available to Commission Counsel, which did happen. In the end result Dr. McGee was not able to assist on the issue of photogrammetry, other than to indicate he had never heard of it being used in this fashion, but did offer useful information with respect to opinions as to the injuries on Neil Stonechild's body. Again, all such information was passed on to Commission Counsel, who then did himself interview Dr. McGee.

23. Subsequently, in late November, 2003, the Saskatoon Police Service "stumbled" across Dr. Lew, Dr. Valerie Rao and Dr. Evan Matshes, who were presenting a seminar in Regina and Saskatoon on child abuse. At a brief meeting with the doctors, Drs. Lew and Rao suggested that it would be useful to have detailed close-up photographs of the injuries prepared.

24. Oddly enough, prior to that time, throughout this entire investigation, no one seems to have thought of doing that (including the Saskatoon Police Service).

25. These detailed photographs were prepared by the University of Saskatchewan Anatomy Department from the original negatives. In order to facilitate this, discussions were held with Commission Counsel and the RCMP during the hearings in early December, at which time the suggestions by Drs. Lew and Rao were passed on. However, neither the RCMP nor Commission Counsel appeared to want to arrange for this to be done themselves and therefore the Saskatoon Police Service, with their knowledge and permission, did so. Once the photographs were received, copies were provided to Commission Counsel and Drs. Lew and Rao and their opinions received. Ultimately, Commission Counsel decided to call Dr. Lew as a Commission witness.

26. While this is a long explanation as to the Saskatoon Police Service's reasons for doing what it did, it is respectfully submitted that the bottom line to the Saskatoon Police Service in doing so was to find out the truth, whatever it was. While criticisms have been levelled at the Saskatoon Police Service for taking the steps it did, this overlooks the fact that the Saskatoon Police Service had committed to pass on all results of the consultations it made **regardless of result**. One must wonder whether the same criticisms would be levelled had the results shown that Gary Robertson's conclusions were correct, as opposed to being incorrect. Indeed if one looks at many of the reports generated by the Issue Team, or a result of the Issue Team, one must acknowledge the reports and conclusions were passed on regardless of the fact that some of them were not particularly complementary to Saskatoon Police Service procedures and policies, etc.

27. In summary, it is submitted that the Saskatoon Police Service went out of its way not to interfere in the RCMP's criminal investigation. The Saskatoon Police Service never conducted any criminal investigation of its own after the matter was referred to the RCMP. All the concerns it had and all matters it discovered were shared with the RCMP and/or Commission Counsel, regardless of what party the results "favoured". Never at any time did it follow-up on tips received or interview any witnesses the RCMP had located or interviewed.

28. The concern of the Saskatoon Police Service, with respect, was to get the best information before the Commission which would best enable the Commission to find out the truth, whatever it may be.

(d) **Improvements and Changes made by the Saskatoon Police Service since 1990, and Recommendations that the Saskatoon Police Service Submits that the Commissioner May Wish to Consider**

29. During the course of his evidence, Deputy Chief Wiks, through reports and testimony, described some of the changes that have been made by the Saskatoon Police Service since 1990, and some changes which are planned for the future.

30. We do not intend to go into detail in this Submission about those but will simply highlight some of the salient changes, improvements and reports which document the same.

31. The most comprehensive report was the audit review conducted in the early 1990s (Exhibit P-149). Deputy Chief Wiks in his testimony directed the attention of the Commission to the most significant parts of that (see testimony of Deputy Chief Wiks commencing on page 6589).

32. Improvements that were made included:

- in the early 1990s the trend to generalization of detectives was abandoned in favour of retaining specialized units with more expertise.

- most importantly, more training and better procedures given much higher emphasis.

- the Deputy Chief himself was involved in the creation of the suspicious death triangle and training with respect to the same (Exhibit P-156).

- in addition, various checksheets and review forms were created and implemented (Exhibits P-157, P-158 and P-159).

- creation of easily portable and accessible policy manuals for field supervisors (now available on in car computers to all members).

- more recently, the Saskatoon Police Service created a Sudden Death Review Committee to examine the investigation of every sudden death before such file can be closed to make sure that a situation such as the investigation of the death of Neil Stonechild does not happen again.
- the Saskatoon Police Service has secured more filing storage space.

- the Saskatoon Police Service has recently revised its policy with respect to retention of notebooks.

- the Saskatoon Police Service has also implemented a “cold case squad” in order to attempt to follow-up on old unsolved cases, as have many other police services.

- the Saskatoon Police Service is currently in the process of installing global positioning system equipment in all of its patrol cars which will track movement of the cars and retain the same for future reference and/or investigations.

- the major crime investigators now work in pairs and investigate all suspicious deaths. Also, suspicious deaths are treated as murder investigations until they are proved not to be. Unsolved ones are retained and classified as murders.

- the Saskatoon Police Service invites the Commission to recommend that the Province of Saskatchewan consider implementing a Medical Examiner system to replace the Province of Saskatchewan’s Coroner system. (see evidence of Dr. Graeme Dowling and Dr. Lew.) In that respect, the Saskatoon Police Service is attaching a copy of a paper delivered by Dr. Emma Lew and Dr. Evan Matshes to the Saskatchewan Association of Chiefs of Police in April of this year which considers in detail how much a system could, in fact, be implemented in Saskatchewan, and there estimated costs thereof.[2]

[2]The “Confidential” notation can be ignored. This paper is being provided to the Commission with their specific knowledge and consent.

Part III
Conclusion

33. As stated earlier in this Submission, the Saskatoon Police Service investigation of the death of Neil Stonechild was inadequate, and the response of the Saskatoon Police Service to the concerns raised by the family of Neil Stonechild, particularly his mother, Stella Bignell, in 1990, was also inadequate. For that, Chief Russell Sabo, on behalf of the Saskatoon Police Service, sincerely apologizes. Mistakes were made. Mrs. Bignell's concerns were not properly addressed. The family of Neil Stonechild, and the community, deserved better. The Saskatoon Police Service wants to assure the family of Neil Stonechild, and the community, that the Saskatoon Police Service has learned from its errors, and will do whatever it can to prevent this from happening again. The Saskatoon Police Service anxiously awaits any and all comments or recommendations this Commission will make with respect to its policies and procedures with a view to improving the service it offers to the community.

All of which is respectfully submitted.

Dated at the City of Saskatoon, in the Province of Saskatchewan, this 6th day of May, 2004.

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Per: _____
Solicitor for Saskatoon Police Service

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Competent Death Investigation:
A Plan for Change in Saskatchewan

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[i] Drs. Waghray, Barber and Bruecks are former Saskatoon pathologists previously involved in the provision of autopsy services to the Coroners office.

[ii] Dr. Burbridge reviewed those sections pertaining to forensic radiology in Saskatoon.

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I. INTRODUCTION

Sudden deaths within the Province of Saskatchewan are investigated by the provincial coroners office. This organization has an important role – that being to determine the *cause* and *manner* of sudden, unexpected and violent death. Such investigation represents the practice of a distinct and recognized **medical subspecialty** called **forensic pathology**. Simply speaking, forensic pathology is defined as the application of knowledge from medicine and pathology to problem solving in the field of law.

At present, medicolegal death investigation is governed by "*The Coroners Act, 1999*", which decrees that the responsibility of death investigation falls to regional coroners who investigate death scenes, determine necessity for autopsy, obtain ancillary investigative information from witnesses, law enforcement, the medical profession and others, and to interpret this information so as to formulate the medical diagnoses of cause and manner of death.

Autopsy services are provided by fee-for-service hospital pathologists in regional health care facilities.

Two critical flaws exist in Saskatchewan's current system of death investigation:

1. **This is a *non*-medical coroners system with predominantly non-medically trained (lay public) investigators.**

   With the complexity of modern day medicine, and advancement/legitimatization of the field of forensic pathology, there is international recognition that non-medical death investigators cannot partake in the unsupervised practice of this **medical subspecialty,** as the role demands critical thinking based on advanced medical knowledge, and forensic data. As such, lay coroners cannot be expected to independently and expertly interpret complex medical and investigative information – a skill that requires a medical doctorate, pathology specialty residency training, and subspecialty board certification in forensic pathology, all combined with extensive experience in the field.

2. **There are *no* forensic pathologists in the *entire* province.**

   Although most non-medical people equate 'hospital pathologist' with 'forensic pathologist', this is in error. Forensic pathology is a distinct subspecialty of anatomic pathology that requires additional training (at least one year) and certification via adjudicated board examination. Most hospital pathologists receive less than two months of training in forensic pathology. This lack of primary training, coupled with minimal experience, may lead to the performance of inadequate forensic autopsies. Furthermore, there is a misconception that forensic pathologists are "*murder*-ologists", and therefore, the relatively low homicide rate in Saskatchewan does not require such experts. Although forensic pathologists are trained and certified to

perform the highly specialized tasks mandated by suspicious death investigations, the majority of their time is spent investigating natural, accidental and suicidal death.

In contrast to the non-medical approach to death investigation offered by the coroners system, a **medical examiners** system of death investigation would offer the services of board certified expert forensic pathologists who would oversee investigation into each of the 1600 annual deaths that are of medicolegal significance. These individuals would be assisted in their role by both full-time (Regina and Saskatoon) and fee-for-service (periphery) field investigators who would be responsible for acquisition of the type of investigative data needed by medical examiners to produce accurate diagnoses. All decision-making responsibility as to scene investigation, autopsy necessity and the determination of cause and manner of death will be the responsibility of the forensic pathologists only.

Contrary to popular belief, Saskatchewan has a high enough caseload to employ at least four forensic pathologists, and to run a forensic pathology center of excellence. All of this can be accomplished with a reasonable increase in the annual funding currently invested in death investigation.

There needs to be recognition on behalf of politicians and members of the public that medical death investigators play important roles which affect law enforcement, crown attorneys, and community health and safety, as well as provide answers to families. Ultimately, legitimate death investigators should serve to ***protect the living through investigation of the dead.***

II. SPECIFIC ISSUES

(a) Coroners

Years ago, society identified the need to investigate the causes of sudden death. Over time, various mechanisms to accomplish this were developed and utilized throughout the world, thereby providing family, community, law enforcement and justice members with answers to important questions. Among others, these include: "**what** was the cause of death?", "**how** did the death occur?", and "**why** did the death happen?". Although there is minor variation between systems, not every death is imminently reportable to medicolegal authorities. In Saskatchewan, a coroner must be contacted immediately in cases where death[1]:

(a) occurred as a result of an accident or violence or was self-inflicted;
(b) occurred from a cause other than disease or sickness;
(c) occurred as a result of negligence, misconduct or malpractice on the part of others;
(d) occurred suddenly and unexpectedly when the deceased appeared to be in good health;
(e) occurred in Saskatchewan under circumstances in which the body is not available because:
    (i) the body or part of the body has been destroyed;
    (ii) the body is in a place from which it cannot be recovered; or
    (iii) the body cannot be located;
(f) was a stillbirth that occurred without the presence of a duly qualified medical practitioner;
(g) occurred as a direct or immediate consequence of the deceased being engaged in employment, an occupation or a business; or
(h) occurred under circumstances that require investigation.

Upon the discovery of a death that falls under the jurisdiction of the coroners branch, a regional coroner will be assigned to provide investigative services.

(i) Appointment of the Coroner

The Chief Coroner for the Province of Saskatchewan is appointed by the Lieutenant Governor to perform, in addition to all of the regular duties of a Coroner (see **Section II.a.iii.** below), a number of administrative functions ranging from supervision and training of coroners, to determining the qualifications of pathologists who provide autopsy service. Coroners are appointed by the Justice Minister (herein referred to as the Minister) to investigate death in the manner described by "*The Coroners Act, 1999*" (herein referred to as *the Act*)[1], and as directed by the chief coroner or Minister.

(ii) Educational Requirements of the Coroner

Although there is direction under the Act for the chief coroner to "establish and conduct programs for the instruction of coroners in their duties" (the Act: II.4.3.d), there are no specific requirements for primary training or experience in any aspect of medicine or the law for either coroners or the chief coroner. There is also no mandate, and minimal to no support for continuing education. In fact, the last two forensic pathology training events in this province were organized and conducted by individuals who were not formally associated with the provincial system of death investigation (2001, 2003).

(iii) Coronial Duties

For a detailed understanding of coroners rights and responsibilities, please refer to Part IV of the Act.[1]

After being alerted to a death, the coroner undertakes some form of investigation that may include death scene examination with seizure of evidence, acquisition of medical and other records relating to the deceased, and issuance of a warrant to take possession of the body. At any time during this process, the coroner may issue a warrant for post-mortem examination – a procedure that is currently performed by fee-for-service pathologists in regional hospitals (see **Section II.b.** below). After receipt of autopsy findings and other ancillary investigative information, the coroner must determine the **cause**[iii] and **manner**[iv] of death, and file a death certificate with the Department of Vital Statistics (pursuant to the Vital Statistics Act, 1995). If an autopsy is not performed, the coroner must use his/her collected data to make the same determination before filing the death certificate.

Throughout the investigation, it is the coroner's responsibility to communicate with family members, and ultimately, provide them with answers to their questions. The importance of these answers to the family must never be underestimated.

The coroner may choose to hold an inquest to, for example, determine how or why an individual died, make public the circumstances of a death, particularly when the death highlights a dangerous practice or condition, or investigate deaths of inmates/wards of the Minister (prisoners, children/others in custody/protection of the Province). Recently, regional

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[iii] **Cause of death** – the disease or injury of any duration that results in anatomic or physiologic changes causing death.

[iv] **Manner of death** – the circumstances under which the he/she met their demise: traditionally viewed as *natural, accidental, suicidal,* or *homicidal.* If after appropriate study, the manner cannot be determined, it is appropriate to state that the manner of death is *undetermined.*

lawyers have been inducted into coronial ranks for the purpose of conducting inquests.

DISCUSSION

"[The National Association of Medical Examiners] contends that all components of forensic pathology fall under the practice of medicine."[2]

Sudden death investigation is a multi-agency effort, with cooperation between law enforcement, medical professionals, various public-service agencies, and forensic experts. Front-line death investigators functioning as coroners, medical examiners, physicians, etc., make vital decisions with far-reaching consequences which influence how death investigation proceeds.[3] As such, the fundamental role played by death investigators in the administration of justice cannot be overemphasized.[4] Therefore, individuals in this role must be properly trained and skilled in the area of medicolegal death investigation as it is widely agreed that a qualified professional is required to investigate death.[5] It is the authors' and others' experience[6], that many inadequately trained individuals (e.g. coroners, EMTs, and non-forensically trained physicians) who come into contact with dead bodies may overstep the limits of their training and experience, and offer inaccurate forensic interpretations. This can lead to confusion and may destroy delicate investigations.

According to Dr. L. Adelson, a noted pioneer in this field, the "statutory duty of [death investigators] is to determine the cause of death as the injury, disease, or the combination of the two responsible for initiating the trail of physiological disturbances, brief or prolonged, which produced the fatal termination".[7] Dr. J. Davis, former Chief Medical Examiner of Miami-Dade County elaborates upon this statement:

> *Statutory duty is not enough! Our expected role goes beyond the "what" and extends into the "why". Should we help explore "why" we are truly serving the community that pays for our service. It is not enough to say 'drowning' and ignore why it occurred or to opine 'blunt head injury' and not to question why the automobile driver lost control.*[8]

Competent systems of death investigation operate under basic principles designed to provide scientifically defensible answers to the above challenge. It has already been established that medicolegal death investigation constitutes the practice of a distinct and recognized medical subspecialty called forensic pathology[2]. In all areas of medicine, the physician (who is always ultimately responsible for the care of the patient, living or dead) collects information from his/her own examinations, and from the supportive investigations of clinical colleagues (whether physician or paraclinical support staff) to make a **diagnosis**. In the world of forensic pathology, the

fundamental diagnoses are those of *cause* and *manner* of death – two determinations that may have profound criminal and civil consequences. Although it is considered medically, scientifically and legally blasphemous for non-physicians to independently practice medicine, there is an apparent paradox in Saskatchewan as the majority of coroners have no formal medical training. Of those physicians who are coroners, none is a pathologist. In fact, the act forbids the same pathologist to be both coroner and autopsy pathologist in any one case (the Act: II.6.a.b.).

Respected forensic pathologist Dr. V. DiMaio has stated that "the coroner system was developed at a time when the lay public knew as much about the science of medicine as the physicians practicing it. Times have changed. Medicine has become an extremely complicated, specialized scientific field."[9] Ultimately, if we are to ensure high quality death investigation services to the public, we must demand that each and every medicolegal investigator possess the knowledge and training necessitated by the complexity and seriousness of the work. The National Association of Medical Examiners states that "only those individuals who possess knowledge of pathophysiology learned through clinical as well as laboratory medicine are capable of making medical decisions and diagnosis at a legal standard...the [forensic pathologist] must ultimately assume the responsibility for the investigation of deaths and in particular all aspects relating to the scene, body examination and autopsy under his/her jurisdiction".[2]

"Because there is universal concern regarding liability, it well behooves any investigating agency to employ a qualified professional who can conduct a thorough and competent death investigation."[5]

Dr. S. Smith writes that "death investigation is not a complicated procedure, but it requires a tenacious, analytical individual who can look past the morbidity associated with this task to effectively and accurately evaluate the findings at a death scene. Quality training is the bedrock on which such a career is based."[5] Dr. R. Hanzlick, a noted American forensic pathologist, has identified three levels of training needed by lay coroners.[10] These include (a) administrative functions (law, procedure, etc.); (b) basic death investigation techniques, along with a common body of knowledge necessary to conduct competent death investigations; (c) continuing education/skills improvement so that lay death investigators may expand "basic minimum competence and skills". Unfortunately, as Saskatchewan lacks basic educational requirements and ongoing training at all of these levels, it is unlikely that our investigators, whether lay or physician, would be able to conduct themselves with *bare minimum competence*. One must consider that having 'years of experience doing the job' does not mean that someone has **ever** done the job *right*. Unlike clinical medicine where improper medical diagnoses/treatment may lead to obvious patient suffering or death, wrong

diagnoses in forensic pathology are less obvious, and may go permanently undetected. Misdiagnoses may allow killers to escape detection and continue to kill, or they may lead to the indictment, prosecution and conviction of innocent individuals.

As previously mentioned, one of the key roles of any medicolegal death investigator is the communication of findings to family members, with the intention of answering their crucial questions. Unfortunately, the utilization of coroners with little to nonexistent training, does not support this function. It is doubtful that someone with such minimal training would be able to properly explain autopsy findings, disease etiology and pathophysiology, risk of occurrence in other family members, etc.

Death scene investigation is a key component of any sudden, unexpected death. Unfortunately, "many people believe that if nothing is seen at the death scene to suggest that a crime has been committed, no investigation is needed. If this careless line of thinking is followed, the investigation will certainly be approached with the wrong frame of mind and evidence that could indicate a crime has been committed will probably be overlooked".[5] Few situations demonstrate the importance of qualified death scene investigators with as much seriousness as cases of sudden unexpected death in infants.[11-15] In this example, the postmortem examination may provide minimal information in the context of the whole case. An examination of the scene and careful consideration of medical, social and circumstantial histories along with autopsy findings, is required to accurately certify cause and manner of death.

It is widely agreed, and aptly stated by Dr. B. Hunt, the retired president of the British Association of Forensic Medicine that "the necessity for [an autopsy] should be decided by an experienced and appropriately trained doctor who should also be responsible for collecting, correlating, and analyzing data, so that any unusual trends would be quickly recognized."[16] An autopsy is a thorough, specialized medical investigation. Just as one does not allow non-physicians to order laboratory, radiologic, or other tests (which are costly and may be unnecessary), coroners should not be granted the authority to demand or deny the performance of an autopsy.

Death investigations, when expertly performed by trained professionals, help to ensure the safety and health of the population.[3,9,12,17,18]

Financial constraint is Saskatchewan's perennial theme. As such, one must accept that like many U.S. regions, non-medical death investigators will continue to play an important role in the functioning of an updated and enhanced system of death investigation. However, within the confines of responsible spending, it is possible to create a radically modified system of expert death investigation. According to forensic pathologist Dr. J. Luke, "there are medical examiner's offices all over [the

United States] where, despite budgetary and other constraints of the most extreme sort, excellence continues to be achieved. This fact attests, above all else, to professional standards maintained, over time and in the face of adversity, which is no easy task. Standards are the key."[19]

II. SPECIFIC ISSUES

(b) Pathologists

Autopsy services are currently provided by hospital-based anatomic or general pathologists. As previously mentioned, although it is commonly assumed that the designation 'pathologist' and 'forensic pathologist' are interchangeable, this is incorrect. Most pathology training programs offer two weeks to two months of training (out of 4/5 years of total training) in forensic pathology, and in most programs, this training is provided by individuals who themselves have no formal expertise in the area. Such exposure as a resident is hardly adequate to qualify someone as an expert in any field, and it is unlikely that rational people would choose to receive medical care from someone with such limited training in any area of medicine. Forensic pathologists are individuals who have trained for at least one year in a high volume forensically-oriented facility, under the guidance of legitimate forensic pathologists, and in a facility recognized by accrediting agencies for postgraduate medical education in forensic pathology. One cannot simply 'do years and years of autopsies' to qualify oneself as an expert because those 'years and years of autopsies' may have been performed incompletely or incorrectly. Forensic pathology cannot be self-taught – forensic pathology is not carpentry.

Randall et al. provide a useful description of the differences between hospital and forensic autopsies:

> "The non-medicolegal autopsy is an examination performed with the consent of relatives, a legal guardian, or other individual(s) authorized by law for the purposes of (1) determining the cause of death, (2) providing correlations between the clinical diagnoses and symptoms, (3) determining the effectiveness of therapy, (4) studying the natural course and extent of disease processes and their modification by therapy, and (5) educating medical personnel...The medicolegal autopsy is an extension of the hospital autopsy...[and] may include, but [is] not restricted to: (1) establishing the cause of death; (2) providing interpretation and correlation of facts and circumstances related to the death; (3) recovering, identifying, and preserving evidence obtained during the medicolegal examination; (4) reconstructing how injury occurred; (5) determining the decedent's identity; (6) estimating a range of time since death; (7) providing a factual, objective medical report for law enforcement and other investigative agencies, the prosecution, and the defense; and (8) assisting in determining the manner of death by separating natural deaths without public health concerns from other natural, unnatural, or suspicious deaths for the purpose of public safety, public health, and for criminal or civil court investigations.[20]

Law enforcement and Crown Attorneys have routinely complained of the poor quality of autopsy service available in Saskatchewan, large proportion of non-

forensic pathologists performing medicolegal cases, and lack of professional qualification. Our proposal (see page 21) ensures high quality forensic pathology is provided by a limited number of individuals, thereby permitting the development of close working relationships between medical and legal investigative staff, and the provision of medicolegal services that are of use to the justice community on the whole.

DISCUSSION

"The stakes are too high to play hunches in forensic pathology."[7]

In 1956, Dr. Alan Moritz, one of the pioneers of the forensic pathology field, wrote a landmark paper entitled "Classical Mistakes in Forensic Pathology".[21] In this article, fourteen cardinal errors made by investigators (particularly pathologists) were identified. Four of these will not be discussed, as they are somewhat *operator-dependent* and therefore not relevant to this particular section. The remaining ten cardinal errors include:

1. Not being aware of the objective of a medicolegal autopsy.
2. Performing an incomplete autopsy.
3. Regarding a mutilated or decomposed body as unsuitable for autopsy.
4. Nonrecognition or misinterpretation of postmortem changes.
5. Failure to make an adequate exam and description of external abnormalities.
6. Not taking adequate photographs of the evidence.
7. Not exercising good judgment in the taking or handling of specimens for toxicologic examination.
8. Failure to collect other evidence for identification, trace, etc.
9. Not examining the body at the scene.
10. Substituting intuition for scientifically defensible interpretation.

These ten errors are routinely made in Saskatchewan by coroners and pathologists. It is therefore troubling that in the fourty-eight years since this article was written, Saskatchewan has been unable to meet basic standards of practice as readily accepted by the forensic pathology community. The circumstances that lead to the Stonechild Inquiry resulted from cardinal errors 1, 2, 4, 5, 6, 8, 9, and 10.

According to Dr. Derrick Pounder (former Alberta deputy chief medical examiner), "[the performance of fee for service autopsies] in the absence of enforced standards is an invitation to bad practice...Requiring that pathologists follow a protocol, and include detailed negative findings in the report to show that they have done so, is an approach applied in Austria and Germany since the 19th century."[22] In medicolegal death investigation, demonstrating the absence of injury (pertinent negatives) may be

as important as the demonstration of obvious injury.[20] Currently, there are no guidelines for Saskatchewan pathologists conducting autopsies, other than the individual must be approved for service by the chief coroner (the Act: II.4.3.g).

Dr. Joseph H. Davis believes that most complex death investigations have **circumstance-dependent diagnoses** with autopsies playing only a minor or noncontributory role.

> "Unlike [gunshot wounds], whose autopsy pattern is unique to cause of death, the reactions of human organs and tissues in complex cases are not unique. The relevance of autopsy findings to cause and manner may be coincidental rather than indicative...The potential for misinterpretation is great when we rely mainly upon the standard tool associated with the practice of pathology – the autopsy...Medical examiner opinions are correct in the majority of cases. They are because most cases are self-solving: auto crashes, homicides, suicides, and so forth. The pathologist's role is more perfunctory than critical. If we passively accept what is proffered by investigators plus what is revealed by autopsy, continued success with simple cases may lull us into a lack of recognition of diagnostic traps in complex situations."[8]

Unfortunately, our pathologists function only as autopsy service providers and as such, there is very much an attitude of 'do the autopsy first, and tell us what we need to go and find out later'. This archaic investigative style is frightening: a fact well illustrated by the discussion of SIDS-type death where investigators frequently use 'negative' autopsies to negate the necessity of further investigation.

The term SIDS (sudden infant death syndrome) was coined several years ago to describe the occurrence of sudden death in apparently normal infants, usually six weeks to six months of age, in which thorough examination of circumstantial/historical findings (including the scene, medical and social histories, etc.) and complete autopsy, fail to reveal a cause of death. Although the term SIDS is falling out of favor with some forensic pathologists[23], its continued use has been approved by some of the modern scientific literature[24] given that detailed consideration has been given to <u>both</u> autopsy and non-autopsy data. In Saskatchewan, hospital pathologists are producing reports labeling cause of infant death as 'SIDS'. This is not only unfortunate, but against international standards, as local pathologists (who are not privy to scene investigation and detailed circumstantial data necessary to deem a death due to SIDS) cannot and should not diagnose SIDS in the morgue. **SIDS is NOT a diagnosis made by autopsy alone.**

In the 2003 report of the Provincial Children's Advocate, there is a recommendation (CDR.61(99); see **appendix**) that autopsies performed on children be done by "pathologists with expertise in pediatric pathology".[25] This recommendation, which originated with the College of Physicians and Surgeons of Saskatchewan, is not adequate. Forensic pathologists are trained to investigate all cases of sudden death, including those of children. Unlike pediatric pathologists, whose specific training is

focused on the pathological evaluation of disease (especially tumor pathology), forensic pathologists evaluate all evidence of injury and disease from the perspective of the law. This is a skill unique to the trained forensic pathologist. We believe that a more accurate recommendation should read "the Government of Saskatchewan must ensure that postmortem examinations of children dying suddenly and unexpectedly and of unnatural causes, be performed by forensic pathologists".

The 2003 Children's Advocate Report also made the important and well-structured recommendation "that the government develop a model to ensure all child deaths are reviewed by "an educated eye"".[25] We believe that fundamental to this recommendation is the utilization of properly trained and credentialed experts in forensic pathology throughout all stages of investigation and child death review. Forensic pathologists are the only individuals who possess legitimate expertise in medicolegal death investigation.

There is a province-wide misconception that forensic pathologists are 'murder-ologists', and therefore, because of the low rate of homicides, there is no need for even one forensic pathologist. This perception is distorted as the majority of medical examiner or coroner's cases are deaths caused by natural, accidental or suicidal means.

It has also been mentioned that Saskatchewan performs autopsies on too few bodies in one year to require a forensic pathologist. According to current chief coroner, Dr. John Nyssen, Saskatchewan coroners investigate an average of 1600 sudden deaths each year, and of these, approximately sixty percent are autopsied. This means that nearly 1000 medicolegal (forensic) autopsies are performed annually. According to the standards for accreditation by the National Association of Medical Examiners, no individual forensic pathologist should be required to perform more than 250 autopsies each year.[26] Given this guideline, Saskatchewan requires at least four qualified forensic pathologists.

The overall societal benefit of employing qualified forensic pathologists should not be limited to the area of death investigation. Forensic pathologists are in the unique position of being the only physicians specifically trained to examine, document *and* interpret injuries.[27,28] Therefore, they play a key part in the evaluation (but typically not the treatment) of living patients with injuries that are of interest to the legal community (e.g., sexual battery, beatings, gunshot wounds, etc.).

II. SPECIFIC ISSUES

(c) Institutional

As previously mentioned, the autopsy service component of Saskatchewan's current system of death investigation is based out of several regional hospitals. Key components of the various mandatory technical services exist at most of these institutions, and are provided and funded by the health care system.

Services provided by local hospitals include:

(i) pathologists (autopsy service)
(ii) physical space (body storage unit and autopsy suite)
(iii) morgue attendants
(iv) autopsy supplies
(v) radiography
(vi) histology
(vii) secretarial services
(viii) security services
(ix) hospital admitting services

(i) Pathologist services

*Issues specifically related to the quality of autopsy service provided by pathologists are outlined above (see **II.b**).*

Pathologists in Saskatchewan are reimbursed for providing medicolegal autopsy services on a fee-for-service basis. These fees range from $500 for 'standard autopsies', to $665 for decomposed bodies, to $1000 for homicides. It must be recognized that this service is being performed by hospital pathologists during their salaried time. In Saskatchewan, the typical salary for such pathologists is $220,000 ($110 per hour [based on 250 work days per year, and eight hours of work per day]). If one assumes that completion of a 'standard autopsy' requires five hours of pathologist time (two hours for autopsy, and three hours of administrative time [dictation and review of reports, organization of photographs/diagrams, review of microscopic slides, communication with coroners and others], this is at a cost to the health care system of at least $550 per autopsy. Complicated cases such as child death and homicides require at least two to three times as much time dedication, with costs therefore ranging from $1100 to $1650 per autopsy.

IMPORTANT NOTE: The Saskatoon Health Region (SHR) Department of Laboratory Medicine, under the direction of Dr. Bruce Murray, has recently determined that SHR pathologists who perform autopsies for coroners will be entering into a contractual relationship with the attorney general. Therefore,

SHR will not be legally responsible for repercussions that may result from such a contract.

(ii) Physical space

None of the mortuaries maintained by the various health regions, meets the standards of accreditation of the National Association of Medical Examiners (NAME; see **Appendix**). However, maintenance of current facilities in 'working order' requires constant financial investment by health regions. This includes operation of refrigeration units (three in Saskatoon alone), and maintenance of the autopsy area. The expense is considerable as proper cleaning supplies alone cost hundreds or thousands of dollars per year. Furthermore, when hardware or physical structures break down or become inadequate, the cost falls upon the hospital or individual department of pathology. The cost of repair of refrigeration units, body moving devices, suction, etc., can be inordinately high.

Safety in the workplace must not be compromised. The performance of autopsies carries with it many inherent risks of infection with blood, airborne and other pathogens. Any facility that conducts autopsies must therefore ensure adequate ventilation, thorough cleaning, proper storage of specimens (including ventilation of formalin fumes), etc. The health and safety of pathologists and support staff is of primary concern in the investigation of any death.

(iii) Morgue attendants

Each region that offers medicolegal autopsy services also provides salaried morgue attendants whose role is to maintain the facility in useable, clean condition, to stock supplies, and to assist with the autopsy as directed by the hospital pathologist (for a review of the NAME standards on the use of autopsy assistants in forensic pathology, please see the **Appendix**). In addition to these roles, morgue attendants are also frequently 'on-call' to allow for 'emergency autopsy service', and for body viewing by family members. In addition to their annual salary of $30,000 to $40,000, on-call wages can be a significant cost to the system. In Saskatoon, there is 2.5 FTE morgue attendant service covered by the SHR across the three hospital sites.

(iv) Autopsy supplies

A plethora of technical and support supplies are mandated by the performance of medicolegal autopsies. Presently, these are purchased and maintained by the hospital providing autopsy service. Such supplies include,

but are not limited to knives, scissors, other dissecting equipment, electric autopsy saws, specimen containers for toxicology, formalin, containers for organ/specimen storage, towels, rags, body bags, etc.

(v) Radiography

Plain film X-ray imaging is an important (and frequently underutilized) component of death investigation. In Saskatchewan, portable hospital X-ray equipment is used to create images from bodies in the morgue. The purchase and maintenance of this equipment is the responsibility of the hospital, as are the supplies necessary to obtain the image (film) and process it (processing equipment, chemicals, etc.).

Of major concern is the use of hospital X-ray technicians in the provision of this service. There is a recognized shortage of qualified technologists working within the districts. Autopsy radiography is frequently viewed as a burden because proper imaging may take up to an hour or more (depending on the complexity and demands of a particular case). In addition to the salary paid to the technologists, the SEIU contract affords these individuals a $50 stipend for 'assistance with an autopsy', as this is a task beyond the normal expectation of their work.

Historically, the Academic Head of Medical Imaging has been allocated the postmortem images for review. This is appropriate, as this person has tended to be an experienced radiologist with a strong academic background. However, forensic radiology experience and training are not a normal part of the imaging residency experience, and it is left to the radiologist in question to develop the knowledge base and experience to interpret autopsy imaging. The process of X-ray interpretation, report creation, and self-education are very time consuming. This additional cost (potentially thousands of dollars per radiographed autopsy) is currently the responsibility of the individual health district.

(vi) Histology

Tissue retained from autopsy for microscopic examination must be trimmed, processed and prepared on glass slides by hospital technicians. At present, hospital-based histotechnologists prepare materials for microscopic examination. Special stains and immunohistochemistry are also provided at markedly increased cost to the system (as high as $50 per slide). Ten or more H&E slides are generally produced in each autopsy.

(vii) Secretarial support

Transcriptionists, and other secretarial support staff are an invaluable part of the provision of medicolegal autopsy services. Again, the cost of maintaining secretarial support to produce pathologists' reports, is covered by the hospital, as is the cost of printing and distributing reports to responsible agencies.

(viii) Security services

After hours access to the morgue for body delivery personnel and law enforcement, is provided by hospital security. These individuals can spend much time waiting for, and providing assistance when bodies are delivered or removed from hospital property.

(ix) Admitting services

In most Saskatchewan hospitals, bodies are registered with, and tracked by admitting officers.

IMPORTANT NOTE: The Department of Laboratory Medicine at Saskatoon Health Region has estimated that the administrative and technical costs of conducting autopsies (not including radiology services or pathologist salaried time) is approximately $600 per autopsy. In return for the provision of these services, the Justice Department provides health regions with a stipend of only $20 per autopsy.

III. A SOLUTION

The following series of recommendations have been developed in an effort to improve the quality of death investigative services in the Province of Saskatchewan. Although it represents sweeping reform, this proposal is intended to establish a system that works within the justice milieu unique to this Province.

Fundamental to our recommendations is the creation of a *Medical Examiner's Act*, and subsequent hiring of legitimate experts in forensic pathology to carry out the bylaws of such an act. Although it may seem logical to 'solve all of Saskatchewan's medicolegal woes by hiring a forensic pathologist', this is limited, and inadequate as Saskatchewan's difficulties originate at the most basic level of death investigation administration. The components of a successful system of death investigation are multiple, and include the intrinsic authority of the office, access to high quality forensic pathology services, and quality front-line death investigators as defined by the medical examiner law. [29]

Forensic pathology services would be based out of unique facilities in both Regina and Saskatoon, allowing for division of death investigation north and south of Davidson (an arbitrary mid-point between the two major cities). Deaths occurring outside of Saskatoon and Regina will be initially investigated by **field investigators**. This role is designed to replace that of the current coroner by providing scene investigation, and evidence/information collection (including digital photography of the scene with electronic transfer to the **medical examiner**). However, unlike the current system that allows significant authority to fall upon non-medical individuals, investigators will be responsible only for data collection (investigation) with rapid relay of this data to the medical examiner. This physician is then responsible for determination of jurisdiction, as well as clarification of what further medical examiner involvement is necessary (forensic pathologist scene review, transport of the body to the city, autopsy, etc.). Only the medical examiner will have the authority to direct investigations, determine the need for autopsy, and to make conclusions about cause and manner of death. Medical examiners are also available for courtroom testimony and participation on local/provincial committees as necessary to best provide expert service to the population they serve.

(a) Medical Examiner Jurisdiction

In any of the circumstances outlined below (within the jurisdiction of the *Medical Examiner's Act)*, the medical examiner shall perform examinations, investigations and autopsies as he or she shall deem necessary to determine the cause and manner of death, to determine identity, or to collect forensic evidence.

1. When any person dies in the province:

   a. Of criminal violence
   b. By accident
   c. By suicide
   d. Suddenly, when in apparent good health
   e. Unattended by a licensed medical doctor
   f. In any prison or penal institution
   g. In police custody
   h. In any suspicious or unusual circumstance
   i. By criminal abortion
   j. By poison
   k. By suspected disease constituting a threat to public health
   l. By disease, injury, or toxic agent resulting from employment

2. When a body is brought into the province without proper medical certification.

3. When a body is to be cremated or donated to the Department of Anatomy and Cell Biology at the College of Medicine (University of Saskatchewan).

(b)Recommendations

1. Abolish the "Coroners Act, 1999".

2. Create the "Medical Examiner's Act".

   The following represent fundamental changes mandated by the Medical Examiner's Act:

   i. <u>Chief Medical Examiner</u>
   This individual would be appointed by the Minister to serve in the capacity of a medical examiner, and as administrator of the provincial system of death investigation. The individual must be a physician (MD or foreign equivalent), meet the legal requirements to practice medicine/pathology in the Province of Saskatchewan, be board certified in anatomical or general pathology, and be board certified (American Board of Pathology, Royal College of Physicians and Surgeons of Canada, or British equivalent) in forensic pathology.

   ii. <u>Deputy Chief Medical Examiner</u>
   This individual is to be appointed by the chief medical examiner to serve in the capacity of medical examiner, and as administrator of the provincial

system of death investigation as directed by the chief medical examiner. The individual must be a physician (MD or foreign equivalent), meet the legal requirements to practice medicine/pathology in the Province of Saskatchewan, be board certified in anatomical or general pathology, and be board certified (American Board of Pathology, Royal College of Physicians and Surgeons of Canada, or British equivalent) in forensic pathology.

iii. Medical Examiner

This individual is to be appointed by the chief medical examiner. Their function is to investigate death as mandated by the *Medical Examiner's Act*, including attendance at death scenes (when requested by law enforcement or other agencies, or when felt appropriate by the respective medical examiner or the chief/deputy chief); perform postmortem examinations on those bodies falling under the jurisdiction of the *Medical Examiner's Act*, to provide testimony as an expert witness in the area of forensic pathology, and to serve as a representative to any committees/boards/hearings related to the areas of justice, public health, medicine etc., in which the participation of a medical examiner is in the best interest of the public (subject to sanction by the chief medical examiner or the Minister). The mandate for teaching is to be determined by the chief medical examiner. The individual must be a physician (MD or foreign equivalent), must be board certified in anatomical or general pathology, and be board certified (American Board of Pathology, Royal College of Physicians and Surgeons of Canada, or British equivalent) in forensic pathology.

iv. Field Investigator

Current coroners who wish to retain a role within the death investigation system would be welcome to function in the capacity of field investigator, at the discretion of the chief medical examiner, and subject to periodic review and re-assessment. Individuals in this position will bear the responsibility of routine death scene investigation, photography of the body and related evidence at the scene, and collection of investigative information (medical records, witness interviews, law enforcement data, etc.). Information is then immediately forwarded to the on-call medical examiner who is responsible for determining jurisdiction and necessity for further investigation (including further death scene review), transport of the body into the medical examiner department, and autopsy. Investigators will be paid a per-case fee of $200 (twice that currently provided under the *Coroners Act, 1999*). Prior to working as a field investigator, each individual undertake training (with examination) in medicolegal death investigation, to be provided by the chief medical examiner and his/her staff.

Full-time senior field investigators will be hired for both Regina and Saskatoon allowing for consistent investigative quality in the largest cities, as well as coordination of all incoming investigative information from field investigators in the periphery. On a rotational basis, full-time investigators will also serve to provide supervisory duties in the autopsy suite for support staff (morgue attendants, others).

3. Create Medical Examiner's Facilities.

Function of a system of expert death investigation requires modern facilities. Due to the province's large size, it is not practical to create one facility that would serve the entire population. As cases currently falling under the jurisdiction of the *Coroners Act, 1999* are roughly equally divided between the northern and southern halves of the province, it is reasonable to create facilities in both Saskatoon and Regina.

As part of the mandate of any medical examiner department is to provide for service, education and related research that is of value to the legal and medical communities, the general public, and the field of forensic pathology, it is reasonable to create a larger and more administratively/academically-oriented office in Saskatoon where professionals and trainees at the University of Saskatchewan can play an active role in furthering these goals. A smaller office would be strategically created in Regina.

Office features in common

Both Saskatoon and Regina medical examiner offices must have the following features:

- offices for professional and support staff
- autopsy suite with capacity for 3 dissection stations
- body storage area with capacity for 30 bodies
- body receiving/processing area
- digital X-ray equipment
- digital photography capabilities
- computer network capable of linking Saskatoon and Regina offices
- meeting area for case conferences with in-house staff, law enforcement, attorneys, etc.
- family 'viewing'/conference room
- staff room (lounge, lunch area)

Office features unique to Saskatoon location

- central records storage area
- transcription (centralized through digital dictation technology)
- forensic photography division
- forensic osteologic/anthropologic laboratory

- classroom (capacity greater than or equal to 100 people; NOTE this is not necessary if this facility is located on the University of Saskatchewan campus)

4. Staff the Medical Examiner's system with a complement of qualified individuals.

   - **Chief Medical Examiner** (one); located in Saskatoon
   - **Deputy Chief Medical Examiner** (one); located in either Regina or Saskatoon; as determined by the Chief Medical Examiner
   - **Medical Examiner** (two); located in either Regina or Saskatoon; as determined by the Chief Medical Examiner and the Minister
   - **Senior (Full Time) Field Investigators** (six); 3 FTE in both Regina and Saskatoon
   - **Forensic Technicians** (four); 2 FTE in both Regina and Saskatoon
   - **Forensic Photographer** (one); 1 FTE in Saskatoon; Regina photographic services to be provided by Forensic Technicians or Medical Examiners
   - **Forensic Radiology Technologist** (one); 0.5 FTE in both Regina and Saskatoon
   - **Administrator** (one); 1 FTE in Saskatoon
   - **Transcription/Reception** (one); 1 FTE in Saskatoon
   - **Receptionist** (two); 1 FTE in both Regina and Saskatoon
   - **Records Technician** (one); 1 FTE in Saskatoon

5. Establish a clear training mandate

   Each member of the medical staff (all medical examiners) will be required to further their education by obtaining continuing medical education (CME) credits as mandated by provincial/national licensing/accreditation bodies. The medical examiners will also have the mandate to ensure appropriate training is given to all field investigators, and that annual continuing educational opportunities be afforded to these individuals. Primary training in the forensic medical sciences is to be considered mandatory for all investigative staff. Failure to obtain/maintain qualifications in this area may lead to termination at the discretion of the chief medical examiner or Minister.

6. Ensure access to subspecialty services

   The following services will be provided, decreasing the need for out-of-province consultations:

   - **Toxicology** – as currently provided by the Provincial lab (Regina) and/or RCMP lab

- **Forensic pediatric autopsies** – to be carried out by board certified forensic pathologists only. All pediatric autopsies within the medical examiners jurisdiction will be performed at the Saskatoon location only.

- **Forensic osteology/anthropology** – to be provided on a consultation basis from existing University of Saskatchewan resources.

- **Forensic dentistry/odontology** – relationship with qualified individual to be established.

- **Medical specialty consults** – neuropathology and other subspecialty areas of pathology will be consulted when appropriate, making use of existing expertise in Saskatchewan.

7. Promote collaboration with outside agencies

   Death investigation is always a collaborative process and many public service groups would greatly benefit from the participation of qualified forensic pathologists. An excellent example is the office of the Children's Advocate, where medical examiners could contribute forensic expertise.

8. Public inquest/inquiry

   The option of public inquest or inquiry into death is important. The medical examiner department will be independent of this process. It is expected that a certain number of cases will receive requests for public inquiry. We suggest that the government appoint a four member panel of individuals (a member of the FSIN, a medical doctor, a lawyer, and a representative of the general public) to review the validity of individual requests. If inquiry is deemed appropriate by this committee, a request should be made to the Justice department who will determine the parameters of such a public hearing.

9. Ensure programs for quality control/assurance are created and utilized

   The quality and accuracy of any medical examiner department must be routinely verified through internal and external review. As part of this process, this office must strive towards and obtain accreditation from recognized agencies in the field, specifically, the National Association of Medical Examiners (NAME).

10. Ensure proper documentation and certification of death province-wide

Cases falling under the medical examiner's jurisdiction will be similar to those outlined by the Coroners Act, 1999. Additionally, all bodies scheduled for cremation, shipment out of province, or for donation to science, must first have a valid, physician-signed death certification submitted for medical examiner review. This allows for the medical examiner to more adequately review deaths, and to question certification that is inadequate or inappropriate. Other jurisdictions have shown this to be a valuable way to identify delayed deaths due to accident, suicide and even homicide.

Logistically and financially, it is not possible to transport all apparent natural deaths falling under medical examiner jurisdiction into Saskatoon or Regina. Field investigators will attend death scenes, take photographs, examine the body and obtain investigative information. This data will be relayed via telephone and internet to the on-call medical examiner, who will determine whether it is necessary to transport the body to the medical examiner department. Detailed scene and body photographs will be used by the medical examiner to classify such non-suspicious apparent natural deaths that occur in remote areas. Optimally, all medical examiner cases would be physically examined by the medical examiner. This provides a satisfactory compromise to accommodate the vast territory but limited financial resources of the province.

11. Ensure public records access to families and their representatives

Medical examiners documents and work products are public record except for cases under active investigation by law enforcement, such as homicides. Family members have ready access to the medical examiner department, including the files of the decedent (except of cases as specified above). The medical examiner will be available to answer specific questions.

12. First Nations communities

The medical examiners department will recognize the unique cultural considerations of First Nations Peoples surrounding death. It will be ensured that one of the three senior investigators in each of Regina and Saskatoon will also function as a liaison with First Nations communities.

(c) Budget

The following budget has been prepared for consideration of typical annual expenses ONLY. It does not include infrastructural or capital costs (e.g. building of a Medical Examiner Facility, X-ray equipment, furniture, primary technology, etc.), nor does it cover unexpected costs associated with such events as mass

disaster. It does not include benefits associated with salaries. Furthermore, it is assumed that costs of general building and ground maintenance, upkeep and function are to be covered separately. As such, the cost of electricity, water, gas, etc. has not been included in this budget.

The following assumptions are made:
- Medical Examiner Department opens 2008-2010
- Average number of medical examiner's cases (including both autopsied and non-autopsied bodies) is 1600 per year
- Average number of autopsied bodies is 1000 per year

i. Salaries

i.a. Chief Medical Examiner
$290,000 (including $5000 educational benefit)
One position
TOTAL – $290,000

i.b. Deputy Chief Medical Examiner
$270,000 (including $5000 educational benefit)
One position
TOTAL – $270,000

i.c. Medical Examiner
$260,000 (including $5000 educational benefit)
Two positions
TOTAL – $520,000

i.d. Full-Time Field Investigators
$55,000 (range: $40,000 - $55,000)
Six positions
TOTAL – $330,000

i.e. Full Time Forensic Technicians
$40,000 (range: $35,000 - $40,000)
Four positions
TOTAL – $160,000

i.f. Forensic Photographer
$45,000 (Range: $35,000 - $45,000)
One position
TOTAL – $45,000

1.g. Forensic Radiology Technologist
$50,000 (Range: $45,000 - $50,000)
Two 0.5 FTE positions
TOTAL – $50,000

1.h. Administrator
$60,000 (Range: $50,000 - $60,000)
One position
TOTAL – $60,000

1.i. Transcription (Clerk Steno III)
$35,000
One position
TOTAL – $35,000

1.j. Receptionist
$35,000
Two positions
TOTAL – $70,000

1.k. Records Technician
$35,000
One position
TOTAL – $35,000

SALARY SUBTOTAL: **$1.865 million**

ii. Operating Expenses

ii.a. Body transportation
TOTAL – $300,000 (estimated)

ii.b. Autopsy-associated (technical) costs
Dissecting blades, cleaning supplies, gloves, laundry, etc.
$200 per autopsy
TOTAL – $200,000

ii.c. Field investigator stipend
For investigators not based in either Regina or Saskatoon.
Approximately 1000[v] cases per year
Rate of $200 per case
TOTAL – $200,000

[v] Note that a figure of 1000 investigations was used instead of 1600. This value is a liberal estimate of the number of cases that would be primarily investigated by field investigators in the periphery. As such, it is assumed that approximately 600 cases would be primarily investigated by salaried senior field investigators in either Regina or Saskatoon.

ii.d. Histology

Service to be provided on a contractual basis by Saskatoon and Regina Health Districts

TOTAL – $50,000 (estimated)

ii.e. Maintenance of records

Color digital photo printing, CD archiving, etc.

Approximately $10.00 per case (1600 medical examiners cases per year)

TOTAL – $16,000

ii.f. General office operational expenses

Estimated cost for both Regina and Saskatoon offices

TOTAL – $75,000

ii.g. Technology support, upgrade and maintenance

Digital cameras for investigators, computer equipment, network equipment and servers)

TOTAL – $50,000

ii.h. Continuing educational objectives

For field investigators and medical examiners

TOTAL – $50,000

ii.i. Library acquisitions/research

Books, journals, electronic resources

Minimal funding for in-house research

TOTAL – $20,000

ii.j. Scene vehicles

Primarily for use by senior field investigators

Two cars, one for each of Regina and Saskatooon offices

$1500 per month per car (including lease, license, insurance, fuel)

TOTAL – $72,000 (estimated)

OPERATIONAL SUBTOTAL: **$1.033 million**

iii. Income from outside sources (estimates)

- Teaching (courses to outside agencies) = $10,000+
- Case consultation (defense attorneys, outside agencies, etc). = $5,000
- Court testimony on civil cases = $5,000
- Documentation for insurance and other agencies = $5,000
- Forensic photography service work = $20,000

TOTAL – $45,000

iv. Indirect savings to the justice system

- Court testimony of pathologists and investigators is covered within their salaries (time only, exclusive of travel expenses)
- Marked decrease in the number of hours wasted by law enforcement investigating cases in which the current system of death investigation is unable to provide confident answers
- Much less likelihood of costly public/judicial inquiry (e.g. the Neil Stonechild Inquiry which is likely to cost three or more million dollars)

TOTAL – $Millions

v. Estimable costs of current death investigative system on Saskatchewan health care

v.i. Pathologist time

See data on page 17
Currently average 960 autopsies per year
Cost of pathologist salaried time to the health care sector: $550 per 'standard autopsy'; $1650 per 'complex autopsy'
Estimating 700 standard, and 260 complex autopsies per year
TOTAL – $814,000

v.ii. Administrative and technical support of autopsy service[vi]

Cost per autopsy is $600
Assuming this is the average cost province-wide, at 960 autopsies per year
TOTAL – $576,000

v.iii. Department of medical imaging expenses

Cost of technologist time to acquire postmortem images and radiologist time to interpret images
TOTAL – $50,000 (estimated)

TOTAL ESTIMABLE COST OF CURRENT CORONERS SYSTEM ON THE HEALTH CARE SYSTEM: $1.44 million

[vi] Figure provided by Dr. Bruce Murray (Head of Laboratory Medicine, Saskatoon Health Region). This does not include pathologists' time. Rather, it includes the cost of autopsy technicians, secretarial support, morgue maintenance, etc.

Budget Summary

Medical Examiner		Coroner	
Budget	$2.898M	**Budget**	$1.332M
		Cost to Health Care	$1.440M
Total	$2.898M	**Total**	$2.772M
Difference between cost of Medical Examiner and Coroners systems: $0.126M			

(d) Implementation

It would be inappropriate to implement a medical examiners system in a piecemeal fashion. Without underlying infrastructure, trained personnel, and proper facilities, a few individuals cannot be expected to fulfill the function of the medical examiner department. As such, we recommend the following:

1. Create a medical examiners commission (which includes the authors of this proposal) to oversee the creation of the medical examiner department.

2. Hire an administrative coordinator to put into action those directives and plans of the commission.

3. With the departure of the current chief coroner:
   a. Appoint an interim chief coroner as directed by the *Coroners Act, 1999*.
   b. Appoint Dr. Emma Lew as consultative chief coroner
      i. This is a volunteer (unpaid) position
      ii. The purpose of this position is to facilitate the transition between the coroners and medical examiners systems
   c. Appoint Dr. Evan Matshes as consultative coroner
      i. This is a volunteer (unpaid) position
      ii. The purpose of this position is to facilitate/coordinate training for current coroners and future field investigators and to facilitate the transition between the coroners and medical examiners systems

4. Establish a training mandate and budget for current coroners to begin the transition process.

IV. CONCLUSION

The investigation of sudden, unexpected and violent death is a serious matter to law enforcement, family members, and society. When the system fails, cause and manner of death remain unexplained, crimes may go unrecognized and/or unpunished, family members have important questions that go unanswered, and there is no opportunity to recognize and avert preventable deaths.

Qualified forensic pathologists with a well-trained support staff are essential in establishing an efficient, comprehensive system of death investigation. Although this requires a significant financial investment, the long-term cost-savings, along with overall benefit to law enforcement, the field of medicine, and family members, far surpass the dollar figure attached to this proposal. Death investigation has suffered for long enough in Saskatchewan. It is time for a change.

V. SUMMARY

1. Death investigation requires medical supervision or overview.

2. Forensic pathology is a distinct and recognized subspecialty within the practice of medicine.

3. Individuals who are not qualified to practice medicine, and who are not trained as forensic pathologists should not be granted the authority to investigate deaths given to non-medical coroners under "The Coroners Act, 1999".

4. Only certified forensic pathologists should provide forensic pathology service.

5. With 1600 annual cases of forensic interest, and nearly 1000 forensic autopsies, Saskatchewan is busy enough to require at least four certified forensic pathologists.

6. The creation of a medical examiners system of death investigation with establishment of rigid standards of practice and training requirements for all forensic pathologists and field investigators is possible within the realm of responsible governmental spending.

7. Two medical examiners offices would be created, one in each of Regina and Saskatoon.

8. All medicolegal autopsies would be performed at these locations by certified forensic pathologists (medical examiners) only. All forensic pediatric autopsies would be performed in Saskatoon, as would all examinations of badly decomposed, burned or skeletonized human remains.

9. Subject to rigid training and approval by the chief medical examiner, current coroners would be offered positions as field investigators. Their role would be to attend non-suspicious/non-homicidal death in peripheral areas, collect data, take photographs, and communicate with the medical examiner who is the decision maker.

10. Forensic pathologists (medical examiners) would always be available for attendance at death scenes as requested by law enforcement.

11. Forensic pathologists (medical examiners) will contribute to committees, groups, meetings, etc. where forensic pathology expertise is of value to society, law, medicine, etc.

12. Inquests/public inquiries into death are important. However, this function must occur independent of the medical examiner department. A committee of individuals appointed by the government will review those cases with public or governmental request for review, and will recommend to the Justice department which cases will be submitted for public inquiry.

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VII. APPENDIX

1. The Coroners Act, 1999
2. National Association of Medical Examiners (NAME) Accreditation Checklist
3. NAME Guidelines for the Utilization of Pathology Assistants in Medical Examiners Offices
4. Pediatric autopsy recommendation from the Saskatchewan Children's Advocate Office [CDR.61(99)]

The Coroners Act, 1999

being

Chapter C-38.01 of *The Statutes of Saskatchewan, 1999* (effective June 1, 2000) as amended by *Statutes of Saskatchewan*, 2003, c.20.

Table of Contents

CHAPTER C-38.01

An Act respecting Coroners

PART I
Short Title, Interpretation and Purpose

Short title

1 This Act may be cited as *The Coroners Act, 1999*.

Interpretation

2 In this Act:

(a) **"chief coroner"** means the Chief Coroner for Saskatchewan appointed by the Lieutenant Governor in Council pursuant to section 4;

(b) **"coroner"** means a coroner appointed by the minister pursuant to section 5;

(c) **"death"** includes a stillbirth within the meaning of *The Vital Statistics Act, 1995*;

(d) **"minister"** means the member of the Executive Council to whom for the time being the administration of this Act is assigned;

(e) **"offence"** means an offence pursuant to the *Criminal Code*;

(f) **"spouse"** means:

(i) the wife or husband of the deceased; or

(ii) a person with whom the deceased cohabited as spouses immediately before his or her death:

(A) continuously for a period of not less than one year; or

(B) in a relationship of some permanence, if they are the parents of a child.

1999, c.C-38.01, s.2.

Purpose

3 The purpose of this Act is to facilitate a coroner system that:

(a) provides for independent and impartial investigations into, and public inquests respecting, the circumstances surrounding unexpected, unnatural or unexplained deaths;

(b) determines the identity of a deceased person and how, when, where and by what means that person died;

(c) uncovers dangerous practices or conditions that may lead to death;

(d) educates the public respecting dangerous practices and conditions; and

(e) publicizes, and maintains records of and the circumstances surrounding, causes of death.

1999, c.C-38.01, s.3.

PART II
Coroners

Chief coroner

4(1) The Lieutenant Governor in Council may appoint a Chief Coroner for Saskatchewan who is responsible for the administration of this Act and the regulations.

(2) Where the office of chief coroner is vacant or the chief coroner is unable by reason of illness, absence or other cause to carry out his or her duties, the minister may designate a coroner to act as a chief coroner until the chief coroner is able to resume his or her duties or until a new chief coroner is appointed.

(3) The chief coroner has all of the powers of a coroner and, in addition, has the power to:

(a) administer this Act and the regulations;

(b) supervise, direct and control all coroners in the performance of their duties;

(c) assign the responsibility to investigate a death or a category of deaths to a coroner;

(d) establish and conduct programs for the instruction of coroners in their duties;

(e) prepare, publish and distribute a code of ethics for coroners;

(f) assist coroners in obtaining medical and other experts where necessary;

(g) determine the qualifications for pathologists for the purposes of this Act;

(h) bring the findings and recommendations of coroners and juries to the attention of the appropriate ministers, persons, agencies or departments of government;

(i) issue public reports;

(j) suspend coroners where they are unable to act or for cause; and

(k) perform any other duties that may be prescribed in the regulations.

1999, c.C-38.01, s.4.

Coroners

5 The minister may appoint one or more persons to be coroners.

1999, c.C-38.01, s.5.

Coroner may be disqualified or re-assigned

6(1) A coroner is disqualified from conducting an investigation or inquest where:

(a) the coroner has attended on the deceased as a physician within 30 days prior to the death;

(b) the coroner has performed a post-mortem examination of the body of the deceased; or

(c) the death may have been caused at a place, in a business or at an event with respect to which the coroner has a financial interest.

(2) The chief coroner may reassign an investigation to another coroner where, in the opinion of the chief coroner, the conduct of a coroner or of a partner, associate, employee or employer of the coroner might be called into question during the investigation.

1999, c.C-38.01, s.6.

PART III
Duty to Notify Coroner of a Death

General duty to notify coroner

7(1) Every person shall immediately notify a coroner or a peace officer of any death that the person knows or has reason to believe:

(a) occurred as a result of an accident or violence or was self-inflicted;

(b) occurred from a cause other than disease or sickness;

(c) occurred as a result of negligence, misconduct or malpractice on the part of others;

(d) occurred suddenly and unexpectedly when the deceased appeared to be in good health;

(e) occurred in Saskatchewan under circumstances in which the body is not available because:

(i) the body or part of the body has been destroyed;

(ii) the body is in a place from which it cannot be recovered; or

(iii) the body cannot be located;

(f) was a stillbirth that occurred without the presence of a duly qualified medical practitioner;

(g) occurred as a direct or immediate consequence of the deceased being engaged in employment, an occupation or a business; or

(h) occurred under circumstances that require investigation.

(2) Every peace officer who is notified of a death pursuant to subsection (1) shall immediately notify a coroner of the death.

1999, c.C-38.01, s.7.

Duty of institutions to notify coroner

8(1) Where an inmate of a jail, military guardroom, remand centre, penitentiary, lock-up or place where the person is held under a warrant of a judge or a correctional facility as defined in *The Correctional Services Act* dies, the person in charge of that place shall immediately notify a coroner of the death.

(2) Where a person dies while in a custody facility as defined in *The Young Offenders' Services Act*, the person in charge of that facility shall immediately notify a coroner of the death.

(3) Where a minor dies while a resident of a foster home, group home or place of safety within the meaning of *The Child and Family Services Act*, the person in charge of that place shall immediately notify a coroner of the death.

(4) Where an involuntary patient admitted pursuant to section 23 or 24, or detained pursuant to section 24.1, of *The Mental Health Services Act* to an in-patient facility within the meaning of that Act dies, the person in charge of that facility shall immediately notify a coroner of the death.

(5) The duty mentioned in this section applies whether or not:

(a) the person died on the premises or in actual custody; or

(b) the person was an inmate, resident or patient at the time of death if the death was caused at that place.

(6) Where a person dies while in a hospital to which the person was transferred from a place mentioned in this section, the person in charge of the hospital shall immediately notify the coroner of the death.

1999, c.C-38.01, s.8.

Duty of police to notify coroner

9 Where a person dies as a result of an act or omission of a peace officer in the course of duty or while detained by or in the custody of a peace officer, the peace officer shall immediately notify a coroner of the death.

1999, c.C-38.01, s.9.

Duty of social workers to notify coroner

10 Where a minor dies while under the care, custody or supervision of the Minister of Social Services, officers or employees of the Department of Social Services or its designates or an agency that has entered into an agreement with the Minister of Social Services pursuant to section 61 of *The Child and Family Services Act*, an officer or employee of the Department of Social Services, its designate or the agency who has knowledge of the death shall immediately notify a coroner of the death.

1999, c.C-38.01, s.10.

PART IV
Investigations

Coroner to investigate deaths

11(1) Where a coroner receives information that there has been a death in an area where the coroner ordinarily exercises his or her responsibilities and he or she has reason to believe that the death occurred under circumstances that require a coroner to be notified, he or she:

(a) may issue a warrant in the prescribed form to take possession of the body, if the body is in Saskatchewan; and

(b) shall conduct any investigation that he or she considers necessary.

(2) Where a coroner has begun an investigation pursuant to subsection (1), no other coroner shall become involved in the investigation unless otherwise directed by the chief coroner.

1999, c.C-38.01, s.11.

Area may be cordoned off and preserved

12(1) A coroner, for the purposes of an investigation, may cordon off the area, for a period not exceeding 48 hours or any greater period the chief coroner approves, where:

(a) the deceased person suffered the injuries or acquired the condition that led to the death; or

(b) the body of the deceased person is found.

(2) The period mentioned in subsection (1) may be extended by the chief coroner for further periods.

(3) A coroner may:

(a) prohibit the removal of objects from the area that is cordoned off pursuant to subsection (1) until the investigation is completed; and

(b) place peace officers in charge of the area to prevent disturbance of the area until the coroner has made any examination that the coroner considers necessary.

1999, c.C-38.01, s.12.

Powers of coroner

13(1) For the purposes of an investigation, a coroner:

(a) may enter and inspect any place where a dead body is and any place from which the coroner has reasonable grounds for believing the body was removed;

(b) may examine and make copies of any records relating to the deceased or his or her circumstances where the coroner believes on reasonable grounds that it is necessary to do so for the purposes of the investigation;

(c) shall take charge of objects that are or might be items of personal property of the deceased and that are found on or near the body of the deceased or in the area where the body of the deceased is found;

(d) with the approval of the chief coroner, may remove objects from the area that is cordoned off pursuant to section 12, whether or not the objects are items of personal property of the deceased; and

(e) may seize bodily fluids obtained from the deceased before death.

(2) Anything removed pursuant to subsection (1) may only be used by the coroner to establish identification and cause and manner of death for the purposes of this Act.

(3) Where a coroner removes anything pursuant to subsection (1), he or she shall retain it until the conclusion of the investigation or inquest and then return it to the person to whom it belongs or, if that person is the deceased, to that person's personal representative or next-of-kin unless the objects removed are prescription medicines of the deceased, illegal drugs or dangerous or illegal items or substances.

1999, c.C-38.01, s.13; 2003, c.25, s.3.

Post-mortem examination

14(1) A coroner may, at any time during an investigation or inquest, issue a warrant for a post-mortem examination of the body, an analysis of the blood, urine or contents of the stomach or intestines or any other examination or analysis of the body that the coroner considers necessary.

(2) A post-mortem examination is to be performed by a pathologist approved by the chief coroner.

(3) Every pathologist who performs a post-mortem examination shall immediately report the results in writing to the coroner.

(4) The pathologist who performs a post-mortem examination may remove and retain any part of the body or object found in the body for the purpose of establishing the cause and manner of death.

1999, c.C-38.01, s.14.

Disinterment

15(1) The chief coroner may order the disinterment of a body for the purposes of any investigation or inquest.

(2) The chief coroner shall send a copy of an order for disinterment by registered mail at least 48 hours before the disinterment to:

(a) the spouse of the deceased or, if there is no spouse, the nearest next of kin; and

(b) the owner or the person in charge of the cemetery or mausoleum where the body is buried or stored.

1999, c.C-38.01, s.15.

Coroner may obtain assistance

16(1) The police service with jurisdiction in the municipality in which the coroner is conducting the investigation or inquest shall give the coroner any assistance that the coroner may require.

(2) A coroner may obtain the assistance of persons other than peace officers for all or part of the investigation or inquest.

1999, c.C-38.01, s.16.

Procedure where inquest not necessary

17 Where, after an investigation, the coroner is of the opinion that an inquest is not necessary, the coroner shall give permission to bury the body and shall, as soon as is practicable:

(a) send to the chief coroner a report respecting the investigation; and

(b) file any information that may be required pursuant to *The Vital Statistics Act, 1995*.

1999, c.C-38.01, s.17.

Chief coroner may direct inquest

18 Notwithstanding section 17, the minister or the chief coroner may direct any coroner to hold an inquest.

1999, c.C-38.01, s.18.

PART V
Inquests

Where inquest necessary

19 A coroner, with the approval of the chief coroner, shall hold an inquest where, after conducting an investigation, the chief coroner is of the opinion that an inquest is necessary to:

(a) ascertain the identity of the deceased and determine how, when, where and by what means he or she died;

(b) inform the public of the circumstances surrounding a death;

(c) bring dangerous practices or conditions to light and facilitate the making of recommendations to avoid preventable deaths; or

(d) educate the public about dangerous practices or conditions to avoid preventable deaths.

1999, c.C-38.01, s.19.

Inquest required where inmate dies

20 A coroner shall hold an inquest into the death of a person who dies while an inmate in a place mentioned in subsection 8(1) or (2), unless the coroner is satisfied that the person's death was due entirely to natural causes and was not preventable.

1999, c.C-38.01, s.20; 2003, c.20, s.4.

Minister may direct inquest

21 The minister may direct the chief coroner or any other coroner to hold an inquest into the death of a person, and the chief coroner or other coroner shall hold the inquest whether or not another coroner has conducted an investigation, held an inquest or done any other act in connection with the death.

1999, c.C-38.01, s.21.

Inquest into multiple deaths

22 Where two or more deaths appear to have occurred from the same event or from a common cause, the chief coroner may direct that one inquest be held respecting all the deaths.

1999, c.C-38.01, s.22.

Inquest not a criminal proceeding

23 The powers conferred on a coroner to conduct an inquest are not to be construed as creating a criminal court of record.

1999, c.C-38.01, s.23.

PART VI
Juries

Number of jurors

24(1) Every inquest shall be held with a jury composed of six jurors.

(2) Any five jurors may return a finding, and a finding returned by five jurors has the same effect as a finding returned by six jurors.

(3) If there are less than five jurors, the coroner shall summon a new jury.

1999, c.C-38.01, s.24.

Exclusions

25 No person who would not be qualified to serve or who would be excluded from serving as a juror pursuant to *The Jury Act, 1998* shall serve as a juror.

1999, c.C-38.01, s.25; 2003, c.20, s.5.

Disqualification of jurors

26(1) No officer, employee, inmate, resident or patient of a place mentioned in section 8, or his or her spouse, shall serve as a juror at an inquest respecting a person whose death was caused or occurred in that place.

(2) No owner of a building or place where a death was caused or occurred, or his or her spouse, shall serve as a juror at an inquest respecting a person whose death was caused or occurred in that building or place.

(3) No owner or employee of a business, or spouse of an owner or employee of a business, shall serve as a juror at an inquest respecting a person whose death was caused or occurred at the place of business or whose death was related to the operation of the business.

1999, c.C-38.01, s.26

Preparation of jury list

27(1) The coroner shall request the chief coroner to obtain a list of persons in the number specified by the coroner who are resident in the geographical area specified by the coroner.

(2) The chief coroner shall request from the person in charge of the register maintained pursuant to subsection 11(1) of *The Saskatchewan Medical Care Insurance Act* a list of names and addresses of persons in the number specified by the coroner who are resident within the geographical area indicated in the request.

(3) Notwithstanding any other Act, on receipt of a request pursuant to subsection (2), the person in charge of the register described in subsection (2) shall randomly select the specified number of names and addresses, and shall send the names and addresses, and no other information from the register, to the chief coroner.

(4) The chief coroner shall forward to the sheriff the names and addresses received pursuant to subsection (3).

(5) Immediately on receipt of those names and addresses, the sheriff shall serve, in the manner specified by section 37 of *The Jury Act, 1998*, each person at the indicated address with a Juror Information Return and Summons and an Application for Relief from Jury Service in duplicate, together with an envelope addressed to the sheriff with postage prepaid.

(6) Section 9 of *The Jury Act, 1998* applies to a person who receives a Juror Information Return and Summons.

1999, c.C-38.01, s.27; 2003, c.20, s.6.

Relief from jury service

28(1) Subject to subsection (2), sections 10 and 11 of *The Jury Act, 1998* apply, with any necessary modification, to relief from jury service pursuant to this Act.

(2) The applications for relief from jury service mentioned in section 10 of *The Jury Act, 1998* shall be made to the chief coroner or any other person that the chief coroner designates who shall determine whether to grant relief.

1999, c.C-38.01, s.28; 2003, c.20, s.7.

Selection of jury

29(1) The coroner may question the persons who are present as a result of a summons to determine their eligibility and suitability as jurors and shall select six persons from those who are present.

(2) Notwithstanding section 27, where the inquest is respecting the death of an employee arising out of his or her work, the coroner shall make a reasonable effort to ensure that the jury summoned shall be composed, wholly or in part, of persons familiar with the type of work the deceased was doing.

(3) Notwithstanding section 27, where, in the opinion of the chief coroner, the circumstances surrounding the death require the jury to be composed, wholly or in part, of persons from a specific racial or cultural group, the coroner shall summon the jury in accordance with the regulations.

(4) Where a jury cannot be formed from the body of persons summoned to appear at the inquest, the coroner may instruct the sheriff to return a sufficient number of persons who are not disqualified or excluded from serving as jurors:

(a) from those person present in court; or

(b) where there is an insufficient number of persons present in court, from the geographical area specified by the coroner pursuant to subsection 27(1).

(5) Section 36 of *The Jury Act, 1998* applies to employers where an employee is summoned for or serves on a jury pursuant to this Act.

1999, c.C-38.01, s.29; 2003, c.20, s.8.

Swearing of jurors

30 When the jurors are assembled, the coroner shall swear them to diligently inquire into the death of the person with respect to whom the inquest is to be held and to give a true finding according to the evidence.

1999, c.C-38.01, s.30.

Failure not ground for impeaching finding

31 A failure to observe the directions contained in this Act respecting the qualifications, exclusion or selection of jurors is not a ground for impeaching the finding returned, unless the omission has resulted in a substantial miscarriage of justice.

1999, c.C-38.01, s.31.

PART VII
Procedure at Inquest

Inquest to be held in public

32(1) An inquest is to be held in public.

(2) A coroner may exclude the public from all or part of an inquest and order that all or part of the evidence not be published or broadcast where the coroner is of the opinion that national security may be endangered or the possibility of serious harm or injury to any person justifies excluding the public and making the order.

(3) A coroner may order that witnesses be excluded from an inquest until they are called to give evidence.

1999, c.C-38.01, s.32.

Procedure where person charged with offence

33(1) Where a person has been charged with an offence arising out of a death, an inquest is to be held only on the direction of the minister.

(2) No person charged with an offence arising out of a death may be compelled to give evidence at an inquest respecting that death.

(3) If a person is charged with an offence arising out of a death for which an inquest is underway, the coroner shall, unless the minister orders otherwise, discharge the jury and close the inquest and shall reopen the inquest only on the direction of the minister.

(4) Where the inquest has been reopened pursuant to subsection (3), a new jury shall be summoned only if, in the opinion of the coroner, it is necessary.

(5) Notwithstanding the other provisions of this section, where a person is charged with an offence arising out of a death and the charge or an appeal from any conviction or acquittal has been finally disposed of or the time for taking an appeal has expired:

(a) the chief coroner may direct a coroner to hold an inquest into the death; and

(b) the person who was charged is a compellable witness at the inquest.

1999, c.C-38.01, s.33.

Procedure where charge likely

34(1) Where it appears likely to the chief coroner that a person will be charged with an offence arising out of a death, a coroner shall delay the holding of an inquest unless directed otherwise by the minister.

(2) Where a person has been charged or it appears that a person may be charged with an offence arising out of a death, the coroner may order that no evidence be published or broadcast without the coroner's permission until:

(a) a charge is laid and the charge or an appeal from any conviction or acquittal of the offence has been finally disposed of or the time for taking the appeal has expired; or

(b) it appears to the coroner that no charge will be laid.

1999, c.C-38.01, s.34.

Procedure for charge other than *Criminal Code*

35(1) Where a person has been charged or where it appears likely to the chief coroner that a person will be charged with an offence pursuant to an Act of Parliament, other than an offence pursuant to the *Criminal Code* arising out of death, or an offence pursuant to an Act or regulation, the chief coroner may direct that an inquest not be held.

(2) Where the chief coroner directs, pursuant to subsection (1), that an inquest not be held, sections 33 and 34 apply.

1999, c.C-38.01, s.35.

Orders where death self-inflicted

36(1) Where, at the inquest, it appears that the death may have been self-inflicted, the coroner may order that no evidence of the proceedings be published or broadcast until a finding is returned.

(2) Where the finding is that a death was self-inflicted, the coroner may order that no evidence of the proceedings be published or broadcast without the coroner's permission other than the name, address and occupation of the deceased, the fact that an inquest has been held and that the death was found to have been self-inflicted.

1999, c.C-38.01, s.36.

Standing

37(1) A coroner may grant standing at an inquest to any person whom the coroner considers to have a substantial interest in the inquest.

(2) A person who has standing at an inquest may:

(a) be represented by counsel or an agent; and

(b) examine and cross-examine witnesses.

1999, c.C-38.01, s.37.

Notice to minister

38(1) A coroner shall notify the minister of the time and place at which an inquest is to be held.

(2) The minister has standing at an inquest and may be represented by counsel.

1999, c.C-38.01, s.38.

Request for counsel

39 On the request of the chief coroner, the minister may appoint counsel to attend at an inquest and to act as counsel to the coroner.

1999, c.C-38.01, s.39.

Notice of inquest

40(1) The coroner shall give written notice of the time and place of the inquest to the following persons that the coroner has knowledge of:

(a) the immediate surviving next of kin of the deceased;

(b) persons who have, in the opinion of the coroner, a substantial interest in the inquest;

(c) persons whose conduct is, in the opinion of the coroner, likely to be called into question at the inquest.

(2) Any person may make a written request to the coroner in charge of an investigation to be notified of the time and place of an inquest, and the coroner shall give written notice of the time and place of the inquest to that person.

(3) Where the conduct of a person who has not been notified of and is not present at the inquest is brought into question, the coroner shall adjourn the inquest and notify that person if it is reasonably practicable to do so.

(4) Failure to notify a person of an inquest does not invalidate the proceedings.

1999, c.C-38.01, s.40.

PART VIII
Witnesses and Evidence

Coroner may summon witnesses

41(1) A coroner may summon any person to:

(a) give evidence on oath at an inquest that is relevant to the subject-matter of the inquest; or

(b) produce in evidence at an inquest any document or thing in the person's control that the coroner may specify that is relevant to the subject-matter of the inquest.

(2) Service of the summons is to be effected by personal service of a copy of the summons by a peace officer.

(3) Where a witness who is required to attend an inquest is confined to a place mentioned in subsection 8(1), (2) or (4), the coroner may order in writing that the witness be brought before the coroner in order to testify at the inquest and direct in the order the manner in which the witness is to be kept in custody until the witness is returned to the place of detention.

1999, c.C-38.01, s.41.

Warrant for arrest

42 Where a person summoned as a witness fails to appear at an inquest in answer to a summons, a coroner may, on proof of service of that summons, issue a warrant directed to any peace officer in Saskatchewan, commanding the peace officer to arrest that person and bring him or her to the inquest.

1999, c.C-38.01, s.42.

Witnesses

43(1) The coroner may permit any person who wishes to give evidence at an inquest to testify, as long as the evidence is not frivolous or vexatious.

(2) A witness at an inquest is entitled to be advised by his or her counsel or agent as to his or her rights, but the counsel or agent may not participate in any other manner in the inquest without leave of the coroner.

(3) Where an inquest is held in the absence of the public, a counsel or agent for a witness is not entitled to be present except when that witness is giving evidence.

1999, c.C-38.01, s.43.

Coroner to administer oaths

44 The coroner shall administer oaths to jurors, witnesses and interpreters according to the practice in the Court of Queen's Bench.

1999, c.C-38.01, s.44.

Jury may question witnesses

45 Members of the jury may ask questions of the witnesses and shall:

(a) view the body if directed by the coroner to do so; and

(b) view the scene where the death may have occurred if directed by the coroner to do so.

1999, c.C-38.01, s.45.

Contempt proceedings

46(1) In this section, "judge" means a provincial court judge.

(2) A coroner may state a case to a judge setting out the facts where, without lawful excuse, a person:

(a) on being duly summoned as a witness or a juror at an inquest, fails to attend at the inquest;

(b) being in attendance as a witness at an inquest, refuses to take an oath or to produce any document or thing in his or her control or to answer any question; or

(c) does any other thing that would, if the inquest had been a court of law having power to commit for contempt, be in contempt of that court.

(3) On receipt of a stated case pursuant to subsection (2), the judge may, on application of and in the name of the coroner, inquire into the matter.

(4) After hearing any witnesses who may be produced against or on behalf of the person mentioned in subsection (2) and hearing any statement that may be offered in defence, the court may punish or take steps for the punishment of that person as if he or she had been guilty of contempt of the court.

1999, c.C-38.01, s.46.

Coroner to maintain order

47 A coroner may make any orders or give any directions that the coroner considers necessary for the maintenance of order at an inquest and may call on a peace officer to enforce those orders or directions.

1999, c.C-38.01, s.47.

Evidence

48(1) At an inquest, a coroner may:

(a) subject to subsection (2), admit any oral testimony, including any testimony obtained by telephone conference call, document or other thing as evidence, whether or not it is admissible as evidence in a judicial proceeding;

(b) exclude anything that the coroner considers to be unduly repetitious or that, in his or her opinion, fails to meet the standards of proof that are commonly relied on by reasonably prudent persons in the conduct of their affairs;

(c) comment on the weight to be given any evidence; or

(d) limit examination or cross-examination of a witness where it is frivolous or vexatious.

(2) Nothing in this section derogates from:

(a) the provisions of any Act expressly limiting the extent to or purposes for which any oral testimony, documents or other things may be admitted or used in evidence; or

(b) any privilege under the law of evidence.

(3) Before a person gives evidence at the inquest, the coroner shall advise the person of the provisions of section 5 of the *Canada Evidence Act* and section 37 of *The Saskatchewan Evidence Act*.

(4) A coroner may employ an interpreter at an inquest.

1999, c.C-38.01, s.48; 2003, c.20, s.9.

Documents

49(1) A copy of a document or other thing may be admitted as evidence at an inquest if the coroner is satisfied of its authenticity.

(2) Where a document has been admitted as evidence at an inquest, the coroner, or with the leave of the coroner the person who produced it or is entitled to it, may cause the document to be photocopied, and the coroner may:

(a) authorize the photocopy to be admitted in evidence in place of the document and order the release of the document; or

(b) furnish a photocopy of the document certified by the coroner to the person who produced or is entitled to it.

1999, c.C-38.01, s.49.

Reports

50(1) The coroner may accept a report, a medical report, a plan, a sketch, a photograph or another document containing information of a factual nature in place of the oral testimony of the maker of that document, and the document is, in the absence of evidence to the contrary, proof of the facts stated in it.

(2) The coroner may, at the request of a person with standing pursuant to section 37 or a juror, require the maker of a document to attend and give evidence at the inquest.

1999, c.C-38.01, s.50.

Adjournment

51(1) The coroner may adjourn an inquest from time to time on the coroner's own motion or if it is shown to the coroner's satisfaction that the adjournment is required to permit a proper inquest to be held.

(2) Where an inquest is adjourned, the coroner shall obtain the oral or written recognizances of the jurors and witnesses for their attendance at the resumption of the inquest.

(3) Where a juror, by reason of illness, death or absence from Saskatchewan, does not attend at the resumption of the inquest, the coroner may proceed with the inquest if at least five jurors are present.

1999, c.C-38.01, s.51.

Coroner unable to continue

52 Where, for any cause, a coroner cannot complete an inquest, another coroner assigned by the chief coroner may complete it and may act on the evidence as if it had been given before him or her.

1999, c.C-38.01, s.52.

Recording of evidence

53(1) An official court reporter appointed pursuant to clause 3(2)(h) of *The Court Officials Act, 1984* shall record the evidence or any part of it by shorthand or by a recording device.

(2) The court reporter shall take an oath that he or she will accurately report the evidence and the coroner shall sign the transcript of the evidence and that transcript is to be accompanied by an affidavit of the court reporter that it is a true report of the evidence.

(3) The evidence taken by a court reporter need not be transcribed unless a transcription is ordered by the minister, by counsel appointed by the minister to act for the coroner at the inquest, by the chief coroner or by any person who requests a transcript and pays to the court reporter the fee ordinarily payable for transcripts of judicial proceedings.

1999, c.C-38.01, s.53.

PART IX
Findings

Jury findings

54(1) The jury shall, at the conclusion of the inquest, retire to consider the evidence and determine the identity of the deceased and how, when, where and by what means the deceased died.

(2) The jury shall not make any finding of legal responsibility.

(3) The jury may make any recommendation that it considers to be of assistance in preventing similar deaths.

1999, c.C-38.01, s.54.

Report to chief coroner
55 At the conclusion of an inquest, the coroner shall forward the following to the chief coroner:

(a) the finding;

(b) any recommendations of the jury;

(c) a list of fees to be paid to the jurors, witnesses, interpreters and any other persons;

(d) a recording of the evidence taken at the inquest;

(e) a transcript of the evidence certified by the coroner at the inquest if the evidence has been transcribed.

1999, c.C-38.01, s.55.

Procedure where jury disagrees
56(1) If the jury cannot agree by a majority on a finding, the coroner may discharge the jury after obtaining any findings of fact that they have been able to agree on.

(2) The coroner shall submit the evidence taken at the inquest, together with any findings of fact that the jury has been able to agree on, to the chief coroner.

(3) The minister or the chief coroner may direct the coroner to summon another jury and hold another inquest or to take any other action that the minister or the chief coroner may direct.

1999, c.C-38.01, s.56.

Coroner to furnish particulars of death
57 Immediately or the close of an investigation or inquest, the coroner shall send to the Director of Vital Statistics any information that is required pursuant to *The Vital Statistics Act, 1995*.

1999, c.C-38.01, s.57.

Coroner may authorize burial prior to inquest
58 A coroner who intends to hold an inquest may authorize the burial of the body before the inquest is held by completion of the medical certificate of death.

1999, c.C-38.01, s.58.

PART X
General

Immunity
59 No action lies or shall be commenced or instituted against the chief coroner, a coroner or an agent acting on behalf of the chief coroner or a coroner for any loss or damage suffered by a person by reason of anything in good faith done, caused, permitted or authorized to be done, attempted to be done or omitted to be done, by any of them, pursuant to or in the exercise of or supposed exercise of any power conferred by this Act or the regulations or in the carrying out or supposed carrying out of any order made pursuant to this Act or any responsibility imposed by this Act or the regulations.

1999, c.C-38.01, s.59.

No obstruction of coroners
60 No person shall knowingly hinder, obstruct or interfere with:

(a) a coroner in the performance of the coroner's duties; or

(b) a person authorized by a coroner to act in connection with an investigation or inquest.

1999, c.C-38.01, s.60.

Body and scene to be preserved
61(1) No person who has reason to believe that a death occurred under circumstances that require it to be reported to a coroner or peace officer shall in any way interfere with or alter the body or its condition unless the coroner so directs.

(2) Where a death has occurred in the wreck of a building, bridge, structure, embankment, airplane, motor vehicle, boat, machine or apparatus, no person shall, except for the purpose of saving life and relieving human suffering, without authority from the coroner, interfere with, destroy, carry away or alter the position of the wreckage or any part of or anything connected with the wreckage.

1999, c.C-38.01, s.61.

Provision of report
62 Where the chief coroner receives a request from any person for a copy of any document mentioned in clauses (a) to (d) and considers it appropriate and in the public interest to do so, he or she may provide a copy of the document to that person on any terms he or she considers appropriate:

(a) a report prepared pursuant to clause 17(a);

(b) the finding or recommendations of a jury at an inquest;

(c) a post-mortem report prepared pursuant to this Act;

(d) a report signed by a duly qualified medical practitioner or the chief coroner as to the cause of death of a person.

1999, c.C-38.01, s.62.

Offence
63 Every person who contravenes a provision of this Act or the regulations is guilty of an offence and liable on summary conviction to a fine of not more than $2,000, to imprisonment for a term not exceeding six months, or to both.

1999, c.C-38.01, s.63

Regulations
64 The Lieutenant Governor in Council may make regulations:

(a) defining, enlarging or restricting the meaning of any word or expression used in this Act but not defined in this Act;

(b) prescribing the remuneration or allowances to be paid to the chief coroner, coroners, jurors, witnesses, interpreters and other persons;

(c) prescribing forms and providing for their use;

(d) prescribing additional rules and procedures for inquests;

(e) respecting the summoning of jurors for the purposes of section 29;

(f) prescribing fees for reports, transcripts and any other documents prepared pursuant to this Act;

(g) prescribing any other matter or thing that is required or authorized by this Act to be prescribed in the regulations;

(h) respecting any other matter or thing the Lieutenant Governor in Council considers necessary to carry out the intent of this Act.

1999, c.C-38.01, s.64.

PART XI
Repeal, Transitional, Consequential and Coming into Force

R.S.S. 1978, c.C-38 repealed

65 *The Coroners Act* is repealed.

1999, c.C-38.01, s.65.

Transitional

66(1) Any person who holds the office of chief coroner or coroner on the day before this section comes into force continues to hold office and is deemed to have been appointed pursuant to the provisions of this Act.

(2) Every proceeding and process initiated, pending or heard in part immediately before the coming into force of this section is to be continued as if it had been initiated pursuant to this Act, and this Act applies with any necessary modification.

1999, c.C-38.01, s.66.

S.S. 1986, c.A-18.2 amended

67(1) *The Amusement Ride Safety Act* is amended in the manner set forth in this section.

(2) Section 28 is amended by striking out "*The Coroners Act*" and substituting "*The Coroners Act, 1999*".

(3) Section 29 is amended by striking out "*The Coroners Act*" and substituting "*The Coroners Act, 1999*".

1999, c.C-38.01, s.67.

S.S. 1993, c.E-6.3 amended

68 Section 20 of *The Electrical Inspection Act, 1993* is amended by striking out "*The Coroners Act*" and substituting "*The Coroners Act, 1999*".

1999, c.C-38.01, s.68.

S.S. 1993, c.G-3.2 amended

69 Section 30 of *The Gas Inspection Act, 1993* is amended by striking out "*The Coroners Act*" and substituting "*The Coroners Act, 1999*".

1999, c.C-38.01, s.69.

R.S.S. 1978, c.H-15 amended

70(1) *The Human Tissue Gift Act* is amended in the manner set forth in this section.

(2) Clause 6(4)(a) is amended by striking out "*The Coroners Act*" and substituting "*The Coroners Act, 1999*".

(3) Section 7 is amended by striking out "section 4 of *The Coroners Act*" and substituting "sections 7 to 10 of *The Coroners Act, 1999*".

(4) Section 15 is amended by striking out "*The Coroners Act*" and substituting "*The Coroners Act, 1999*".

1999, c.C-38.01, s.70.

REGINA, SASKATCHEWAN
Printed by the authority of
THE QUEEN'S PRINTER

The Coroners Regulations, 2000

being

Chapter C-38.01 Reg 1 (effective June 1, 2000) as amended by Saskatchewan Regulations 55/2002.

Table of Contents

CHAPTER C-38.01 REG 1
The Coroners Act, 1999

Title

1 These regulations may be cited as *The Coroners Regulations, 2000*.

Interpretation

2 In these regulations, "Act" means *The Coroners Act, 1999*.

9 Jne 2000 cC-38.01 Reg 1 s2.

Coroner's fees

3 The fee payable to a coroner:

(a) for conducting an investigation and making a report, where an inquest is not held, is $100;

(b) for each hour in excess of two hours spent travelling to, visiting and returning from the scene of a death is $17.50;

(c) for conducting an investigation and holding an inquest, including preparing a report and completing documents, is $125; and

(d) for each hour spent conducting an inquest is $17.50.

9 Jne 2000 cC-38.01 Reg 1 s3.

Post-mortem examinations

4(1) The fee payable for a complete post-mortem examination, including any necessary microscopic examination, histological report or tissue report, conducted by a duly qualified medical pathologist is:

(a) $230 for a post-mortem examination begun before April 1, 2000; and

(b) $500 for a post-mortem examination begun on or after April 1, 2000.

(2) The fee payable for an external post-mortem examination only is $30.

(3) Where the post-mortem examination mentioned in subsection (1) is conducted:

(a) on a decomposed body or on the body of a homicide victim, the fee payable is $340 for an examination begun before April 1, 2000;

(b) on a decomposed body, the fee payable is $665 for an examination begun on or after April 1, 2000; and

(c) on the body of a homicide victim, the fee payable is $1,000 for an examination begun on or after April 1, 2000.

9 Jne 2000 cC-38.01 Reg 1 s4.

Fees for use of facility

5 The fee payable:

(a) for the use of a room in a hospital for a post-mortem examination is $20;

(b) for the use of a room in a facility other than a hospital for a post-mortem examination is $55; and

(c) for the use of a room in any facility for holding a body temporarily, where the post-mortem examination is not being conducted in that facility, is $10.

9 Jne 2000 cC-38.01 Reg 1 s5.

Fees for witnesses, jurors, medical practitioners and professional persons

6 The fee payable:

(a) to a witness or juror for each day that the witness or juror is absent from his or her residence attending an inquest is $15;

(b) to a pathologist or medical practitioner required to give evidence at an inquest is the amount prescribed in Table 6 of the Appendix to *The Queen's Bench Regulations*; and

(c) to a professional person, other than a person mentioned in clause (b), required to give evidence at an inquest as a result of professional services rendered by the professional person is $52.50 for each half day.

9 Jne 2000 cC-38.01 Reg 1 s6.

Transportation costs

7 The amount payable for transportation costs incurred by a coroner, juror, witness, interpreter or any other person required to travel in connection with an investigation or inquest:

(a) where he or she uses commercial transportation, is the amount of the actual fare paid, where supported by receipts; or

(b) where he or she uses his or her personal vehicle, is the rate currently payable in accordance with the tariff of travel expenses approved pursuant to *The Public Service Act, 1998* for employees of the public service.

9 Jne 2000 cC-38.01 Reg 1 s7.

Subsistence costs

8 The amount payable for subsistence for a coroner, juror, witness or other person required to be absent from his or her residence in connection with an investigation or inquest:

(a) for hotel or motel accommodation, is the actual and reasonable amount paid where supported by receipts; and

(b) for expenses, other than those mentioned in clause (a), is the rate currently payable in accordance with the tariff of sustenance expenses approved pursuant to *The Public Service Act, 1998* for employees of the public service.

9 Jne 2000 cC-38.01 Reg 1 s8.

Transportation services

9(1) In this section, **"ambulance firm"** means any person, agency, private firm, hospital, municipality or group registered with the Department of Health that provides ambulance services.

(2) The amount payable for transportation of a body:

(a) by an ambulance firm is the amount prescribed by the district health board for the health district where the transportation took place; or

(b) where the service is not provided by an ambulance firm, is $75 per day of transportation and $0.65 per kilometre, each way.

(3) Where a person involved in transporting a body is required to wait, the charge for each hour of waiting is $25.

(4) Where more than one body is transported, the fee for each additional body transported is $25.

9 Jan 2000 eC-38.01 Reg 1 s9.

Special cases

10 The minister may authorize any further fees or payments that the minister considers reasonable respecting services required and provided in the administration of the Act.

9 Jan 2000 eC-38.01 Reg 1 s10.

11 **Repealed.** 12 Jly 2002 SR 84/2002 s2.

Juries

12(1) Where, in the opinion of the chief coroner, the circumstances surrounding the death require the jury to be composed, wholly or in part, of persons of Aboriginal ancestry, the chief coroner may:

(a) request from the person in charge of the register maintained pursuant to subsection 11(1) of *The Saskatchewan Medical Care Insurance Act* a list of names and addresses, in the number specified by the coroner, of persons who are:

(i) registered Indians pursuant to the *Indian Act* (Canada); and

(ii) members of an Indian band within the geographical area indicated in the request; or

(b) request from the Indian band or bands in the geographical area specified by the coroner a list of names and addresses of band members in the number specified by the coroner selected from the band list by a method determined by the chief coroner.

(2) Where the chief coroner makes a request pursuant to clause (1)(a), subsections 27(3) to (6) of the Act apply.

(3) Where the chief coroner makes a request pursuant to clause (1)(b), subsections 27(4) to (6) of the Act apply.

9 Jan 2000 eC-38.01 Reg 1 s12.

Forms

13(1) A notification of death pursuant to section 7, 8, 9 or 10 of the Act is to be in Form A of the Appendix.

(2) A warrant to take possession of a body pursuant to clause 11(1)(a) of the Act is to be in Form B of the Appendix.

(3) A warrant pursuant to subsection 14(1) of the Act requiring a post-mortem examination or other examination or analysis is to be in Form C of the Appendix.

(4) A report of a coroner pursuant to clause 17(a) of the Act is to be in Form D of the Appendix.

(5) An order directing an inquest pursuant to section 21 of the Act is to be in Form E of the Appendix.

(6) A summons to an inquest witness pursuant to subsection 41(1) of the Act is to be in Form F of the Appendix.

(7) An order to a witness pursuant to subsection 41(3) of the Act who is confined to a place mentioned in subsection 8(1), (2) or (4) of the Act is to be in Form G of the Appendix.

(8) A warrant pursuant to section 42 of the Act for a witness who fails to appear is to be in Form H of the Appendix.

(9) A jury report prepared pursuant to section 54 of the Act is to be in Form I of the Appendix.

9 Jan 2000 eC-38.01 Reg 1 s13.

R.R.S. c.C-38 Reg 1 repealed

14 *The Coroners Regulations* are repealed.

9 Jan 2000 eC-38.01 Reg 1 s14.

Coming into force

15(1) Subject to subsection (2), these regulations come into force on the day on which section 1 of *The Coroners Act, 1999* comes into force.

(2) If these regulations are filed with the Registrar of Regulations after the day on which section 1 of *The Coroners Act, 1999* comes into force, these regulations come into force on the day on which they are filed with the Registrar of Regulations.

9 Jan 2000 eC-38.01 Reg 1 s15.

Saskatchewan Justice

Form A

Notification of Death
(Sections 7 to 10 of The Coroners Act)

Name of Deceased _____ . _____
(Please Print) *(Surname)* *(Given Names)*

Date of Birth: ____ -- ____ Date of Death: _____ Place of Death: _____

If decedent is 20 years or under Parent(s) Name: _____

Parent(s) Address: _____

Under care of Social Services: Yes ☐: No ☐: Unknown ☐

North American Indian: Yes ☐ (this includes non-status);

Band and/or Treaty Number: _____

Métis: Yes ☐: Inuit: Yes ☐: Asian: Yes ☐: Caucasian: Yes ☐:

Admitted or Detained pursuant to *The Mental Health Services Act*: Yes ☐: No ☐: Unknown ☐

Post-mortem Ordered: Yes ☐: No ☐: If yes indicate hospital: _____

Registration of Death completed: Yes ☐: No ☐

Inquest Recommended: Yes ☐: No ☐: Undecided ☐

Briefly Describe Circumstances of Death:

Name of Transportation Service When Provided at Coroner's Direction:

_____

Coroner: _____ _____
(Print Name) *(Signature)*

This form must be completed and forwarded to the Coroners Branch of the Department of Justice or faxed to (306) 787-5363 within 48 hours of becoming aware of the death.

Saskatchewan Justice

Form B

Warrant to Take Possession of a Body
(Clause 11(1)(a) of The Coroners Act)

TO _____

of _____, Saskatchewan, a peace officer in Saskatchewan,

and all other peace officers in Saskatchewan

I, _____, a Coroner for Saskatchewan,

have reason to believe that _____ died under circumstances

that require investigation, and I am required to conduct an investigation into the circumstances surrounding the death and

the manner and cause of death of _____

I order you to cause the body of _____ to be taken into

your custody, or the custody of any other peace officer in Saskatchewan, so that I may conduct the investigation.

DATED this _____ day of _____, _____

_____
A Coroner for Saskatchewan

Saskatchewan Justice

Form C

Warrant for Post-mortem or Other Examination

(Subsection 14(1) of The Coroners Act)

TO _____

I, _____, _____
(Please Print) *(Surname)* *(Given Name)*

a Coroner for Saskatchewan, direct you to make a post-mortem examination and analysis of the body of

_____, _____
(Surname) *(Given Name)*

and Estimation of date of death: Yes ☐ No ☐; General toxicology: Yes ☐ No ☐;

Special toxicology for: _____, Blood alcohol: Yes ☐ No ☐

Other: _____

and to report the results to me in writing.

DATED this _____ day of _____, _____.

_____
A Coroner for Saskatchewan

_____
Coroner's Printed Name

Briefly Describe Circumstances of Death:

Information about the Decedent:

Date of birth: _____ Estimate of date of death: _____

Saskatchewan PHN: _____

Saskatchewan Justice

Form D

Report of Coroner When Inquest Not Necessary

(Clause 17(b) of The Coroners Act)

I, _____, a Coroner for Saskatchewan, residing at _____, Saskatchewan, report that, after an investigation by me, I am of the opinion that

_____, date of birth: _____)

of _____ in _____ came to his/her _____

death on the _____ day of _____, _____ at _____

of _____ by the following means:

Medical Cause of Death: _____

_____

Manner of Death: _____
(Natural, Accidental, Suicide, Homicide or Undetermined)

Circumstances:

After this investigation I am of the opinion that a public inquest is not necessary and I have completed the required Registration of Deaths and have permitted the disposition of the body of

_____

DATED at _____, this _____ day of _____, _____.

_____
Signature of Coroner

Form E

Saskatchewan Justice

Order Directing Inquest

(Section 21 of The Coroners Act)

I, _____, Minister of Justice and Attorney General for Saskatchewan, pursuant to the power vested in my by The Coroners Act, 1999, direct _____ of _____, Saskatchewan, being the Chief Coroner or a Coroner for Saskatchewan, to hold an inquest pursuant to The Coroners Act, 1999 into the death of _____, late of _____, who died at _____, Saskatchewan, on or about the _____ day of _____, _____.

DATED at Regina, Saskatchewan, this _____ day of _____, _____.

_____

Minister of Justice and Attorney General for Saskatchewan

Form F

Saskatchewan Justice

Summons to Inquest Witness

(Subsection 41(1) of The Coroners Act)

To _____

You are summoned to appear before me on _____ the _____ day of _____, _____, at _____ a.m./p.m. at _____, Saskatchewan to give evidence at the inquest into the death of _____.

DATED this _____ day of _____, _____.

Please bring with you all records and documents in your control relating to the death of _____.

_____

A Coroner for Saskatchewan

Form G

Saskatchewan Justice

Order Requiring Attendance of a Confined Witness

(Subsection 41(3) of The Coroners Act)

To _____ of _____

WHEREAS _____ is required as a witness to attend an inquest into the death of _____ to be held on the _____ day of _____, _____, at _____ Saskatchewan commencing at _____.

WHEREAS I am informed that _____ is confined at _____.

I THEREFORE DIRECT you to deliver him/her to a peace officer so that he/she may be brought before the presiding Coroner to testify at the inquest.

I FURTHER DIRECT the peace officer to whom custody of the said _____ is given to provide for safe keeping of him/her and to have him/her available as a witness at the inquest into the death of _____ at the time and place stated, and to return him/her to the custody of _____ at _____ after he/she is no longer required as a witness.

DATED this _____ day of _____, _____, at _____, Saskatchewan.

_____

A Coroner for Saskatchewan

Form H

Saskatchewan Justice

Warrant for Witness Who Fails to Appear

(Section 42 of The Coroners Act)

To peace officers in Saskatchewan:

WHEREAS _____ was summoned as a _____ to appear at an inquest into the death of _____, AND _____ failed to appear as required by the summons;

THIS IS TO COMMAND YOU to arrest _____ and bring _____ to the inquest at _____, Saskatchewan.

DATED this _____ day of _____, _____, at _____, Saskatchewan.

_____

A Coroner for Saskatchewan

Form I

Saskatchewan Justice

Jury Report
(Section 54 of The Coroners Act)

We, (Please Print)

_____ of _____

_____ of _____

_____ of _____

_____ of _____

_____ of _____

_____ of _____

having been sworn as the jury to inquire into the death of a person identified as

_____;

at an inquest held at _____, Saskatchewan

on the _____ day of _____, _____, determined the following:

1. Name of deceased: _____
2. Date and time of death: _____
3. Place of death: _____
4. Cause of death: _____
5. By what means: _____

In the interest of avoiding similar deaths in the future we recommend the following:

_____

_____

_____

_____ _____
(Signature of Jury Member) (Signature of Jury Member)

_____ _____
(Signature of Jury Member) (Signature of Jury Member)

_____ _____
(Signature of Jury Member) (Signature of Jury Member)

This report was received by me this _____ day of _____, _____.

_____
A Coroner for Saskatchewan

9 Jun 2000 rC-38.01 Reg 1.

REGINA, SASKATCHEWAN
Printed by the authority of
THE QUEEN'S PRINTER

ACCREDITATION CHECKLIST

VERSION I

6 Feb 1997
Amended 10 February 1998
Amended 29 October 1998
Amended 15 October 1999
Amended 23 February 2000
Amended 14 September 2000
Amended 12 October 2001
Amended 27 September 2002
Amended 18 February 2003

Date of Issuance: March 1997
Date of Expiration: March 2003

CONTENTS

NAME ACCREDITATION CHECKLIST

	PHASE	YES	N/A	NO
I. FACILITIES				
I.1 Does the office have sufficient space, equipment, and facilities to support the jurisdiction's volume of medicolegal death investigations?	II	___	___	___
I.2 Are lockers, changing areas and shower facilities available for male and female employees?	I	___	___	___
1A BODY HANDLING AREAS				
1A.1 Is the body receiving area adequate in size and designed to accommodate the usual volume of incoming and outgoing bodies with safety and security?	II	___	___	___
1A.2 Are body receiving and handling areas sequestered from public view?	II	___	___	___
†1A.3 Is there a method by which family or friends can make positive identification of decedents, (e.g. a viewing room, "instant photography, closed circuit television, digital photography, etc.)	II	___	___	___
1A.4 Is refrigerated storage space sufficient to accommodate the number of bodies and their handling during usual and peak loads?	II	___	___	___
1A.5 Is the refrigerated storage space easily accessible to the autopsy room and to the body release area?	I	___	___	___
1B AUTOPSY SUITES				
1B.1 Can the autopsy room accommodate the usual and peak case load, including the typical number of autopsies and external examinations, the normal complement of autopsy and laboratory personnel, official participants and observers from cooperating agencies, and other authorized personnel?	II	___	___	___
1B.2 Does the ventilation system control odor and fumes, and prevent them from entering and leaving the autopsy and body storage areas?	I	___	___	___
1B.3 Does the heating/cooling systems systems maintain a working environment conducive to individual performance?	I	___	___	___
1B.4 Is the lighting adequate?	II	___	___	___
1B.5 Is a body scale located in or near the autopsy room?	I	___	___	___

† changed 10/12/01

	PHASE	YES	N/A	NO
1B.6 Is suction available?	I	___	___	___
1B.7 Are sufficient autopsy stations available for the usual case volume?	II	___	___	___
1B.8 Is there a stable surface for the dissection of each case (either table stand or permanent structure; not mere cutting board)?	I	___	___	___
1B.9 Is a scale for weighing adult and pediatric organs accessible to all autopsy/dissection areas?	II	___	___	___
1B.10 Are floor, sink, and table drains able to handle autopsy waste and small particulate matter, with clean-out traps easily accessible?	II	___	___	___
1B.11 Are surfaces for preparation of documents and records far enough removed from the examination areas to avoid inadvertent contamination?	I	___	___	___
1B.12 Are surfaces in the autopsy room nonporous and easily cleaned?	I	___	___	___
1B.13 Is dictation equipment or other means of recording postmortem findings available in the autopsy room, adjacent to the autopsy room, or in physician's offices?	II	___	___	___
1B.14 Are x-ray view boxes present to permit concurrent anatomical orientation during the autopsy?	I	___	___	___
1B.15 Is a separate or functionally isolated room available for the storage and autopsy of decomposed bodies and known highly infectious bodies?	I	___	___	___
1C ADMINISTRATIVE SPACE				
1C.1 Is sufficient office space available for medical examiners, investigators, administrative and other office staff?	II	___	___	___
1C.2 Is each pathologist's office furnished with a desk, shelves, file cabinets, microscope, and dictation equipment?	I	___	___	___
1C.3 Are facilities available to support individual and group employee functions, including, where applicable, break/dining area, meeting/conference area and library?	I	___	___	___
1C.4 Is the administrative area separate from the autopsy rooms, laboratories and body receiving area so that it is freely accessible to visitors who have legitimate business with the office without exposure to autopsy activity?	II	___	___	___

	PHASE	YES	N/A	NO
1D STORAGE SPACE				
1D.1 Is there general storage space available for the needs of the office?	II	___	___	___
1D.2 Is there sufficient records storage space available for a minimum of five years of current reports and records?	II	___	___	___
1D.3 Is special storage space available and secured for decedent personal effects, evidence recovered during investigations, tissues and evidence recovered from the body, and specimens held for additional laboratory analysis?	II	___	___	___
1D.4 Is space available for examination of clothing, personal effects and other evidence discovered on or about the body?	I	___	___	___
1D.5 Are tissue storage areas ventilated and free of formaldehyde or putrefied tissue odors?	I	___	___	___
1D.6 Is there separate storage space for reagent gases, solvents and chemicals?	II	___	___	___
1E RADIOLOGIC FACILITIES				
1E.1 Is radiographic equipment installed in a convenient location in or near the autopsy room?	I	___	___	___
1E.2 Is the radiographic equipment shielded in accord with the radiation safety standards promulgated by state and federal regulations?	II	___	___	___
¶1E.3 Is in-house x-ray equipment periodically assessed for performance improvement, radiation protection, x-ray beam collimation, and biomedical safety?	II	___	___	___
1F HISTOLOGIC LABORATORY SPACE				
1F.1 Is adequate space and equipment provided for tissue cutting and for histologic preparation of microscopic slides, including an area for special staining methods?	II	___	___	___
1F.2 Is each work station supplied with electricity and water and properly vented to remove solvent and fixative fumes?	II	___	___	___

¶ changed 10/12/01

	PHASE	YES	N/A	NO
1G TOXICOLOGIC LABORATORY SPACE				
1G.1 Does the toxicology laboratory have suitable space, equipment, scientific instrumentation, reagents and supplies to manage the caseload?	II	___	___	___
1H MAINTENANCE				
1H.1 Does the office have a written and implemented policy or standard operating procedure, signed within the last two years covering facility maintenance?	II	___	___	___
1H.2 Are the facilities and all work areas clean and well maintained?	II	___	___	___
1H.3 Are public access areas comfortable, clean, and free from odor?	I	___	___	___
1H.4 Are autopsy tables and dissection areas disinfected with bactericidal/virucidal solutions on a daily basis if they have been used?	I	___	___	___
1H.5 Is the scientific equipment placed on a documented periodic maintenance schedule?	I	___	___	___
1H.6 Are all scales periodically calibrated with known weights?	I	___	___	___
1H.7 Are the heating/ventilation/air conditioning, plumbing, and electrical systems of the physical plant scheduled for periodic routine inspection and preventive maintenance?	I	___	___	___
1I SECURITY				
1I.1 Does the office have a written and implemented policy or standard operating procedure, signed within the last two years covering facility security?	II	___	___	___
1I.2 Is access to all areas of the facility controlled?	I	___	___	___
1I.3 Is access to body receiving and handling areas limited and controlled?	II	___	___	___
1I.4 Is the records storage space secure, with controlled access and to ensure the integrity of the reports?	I	___	___	___
¶1I.5 Are laboratories physically separate from other work areas, and do they have controlled access?	I	___	___	___
1I.6 Is an after-hour locked storage area or depository available for evidentiary material?	I	___	___	___

@ changed 10/29/98

	PHASE	YES	N/A	NO
2. SAFETY				
2.1 Does the office have a written and implemented policy or standard operating procedure, signed within the last two years on safety?	II			
2.2 Are employees and visitors safe from physical, chemical, electrical and biologic hazards?	II			
#2.3 Are safety policies and procedures written and posted or readily accessible?	II			
2.4 Is a written blood-borne pathogen control program in place?	II			
#2.5 Are standard precautions ("universal precautions") used when performing autopsies and handling biological specimens?	II			
#2.6 Are all potentially exposed or at risk office staff offered vaccination for hepatitis B?	II			
2.7 Are first aid kits, safety showers and eye washes strategically located in the laboratories?	II			
2.8 Are dedicated and marked specialized safety containers used for disposing of hazardous chemicals and biologic waste?	II			
2.9 Are safety cabinets or explosion-proof rooms in use for storage of volatile solvents?	II			
2.10 Are electrical outlets and equipment properly grounded and ground fault circuit interrupters utilized in areas where water may pose an added risk?	II			
^2.11 Are autopsy dissecting sinks equipped with back flow protection devices?	I			
3. PERSONNEL				
3.1 Does the office have a written and implemented policy, signed within the last two years covering personnel issues?	II			
3.2 Are there written and implemented procedures for discipline and removal of staff for cause?	II			
3.3! Is there adequate technical staff coverage to handle the routine daily caseload for the following areas:				
A. autopsy assistance?	I			
B. histology?	I			
C. forensic photography?	I			
D. x-ray?	I			
E. toxicology?	I			
F. investigations?	I			

@ changed 10/29/98
^ changed 9/14/00

	PHASE	YES	N/A	NO
3.4 Is there adequate nontechnical staff coverage to handle the routine daily caseload for the following areas:				
A. administration?	I			
B. visitor reception?	I			
C. medical transcription?	I			
D. records keeping?	I			
E. data analysis?	I			
F. body handling and transportation?	I			
G. custodians/cleaning personnel?	I			
3A MEDICAL EXAMINERS				
3A.1 Is the chief medical examiner (or coroner or coroner's pathologist) a pathologist certified by the American Board of Pathology in anatomical pathology or equivalent certification and have two years of forensic pathology experience?	II			
3A.2 Is the chief medical examiner a forensic pathologist certified by the American Board of Pathology in forensic pathology?	I			
#3A.2! Is the chief medical examiner licensed to practice medicine or osteopathy by the appropriate state or jurisdictional authority granting such licenses where the office is located?	II			
3A.3 Is the chief medical examiner employed full-time and are the office duties his or her primary professional obligation?	I			
@3A.4 When the chief medical examiner is not available, is a deputy chief medical examiner or an associate medical examiner who possesses qualifications similar to those of the chief medical examiner available in an alternate capacity?	I			
#3A4.1 When the chief medical examiner is not available, is there a deputy chief medical examiner or an associate medical examiner who is licensed to practice medicine or osteopathy by the appropriate state or jurisdictional authority granting such licenses where the office is located?	II			
3A.5 Are all associate/deputy medical examiners or physicians responsible for postmortem examinations and autopsies pathologists who have completed a training program in anatomic pathology accredited by the Accreditation Council for Graduate Medical Education (ACGME) or equivalent?	II			
#3A5.1 Are all associate/deputy medical examiners or physicians responsible for postmortem examinations and autopsies licensed to practice medicine or osteopathy by the appropriate state or jurisdictional authority granting such licenses where the office is located?	II			

@ changed 10/29/98
# changed 10/15/99

	PHASE	YES	N/A	NO
(#3A.6 Are all associate/deputy medical examiners or physicians ultimately responsible for postmortem examinations and autopsies, pathologists who are board certified in anatomic pathology by the American Board of Pathology and who have completed at least one year of supervised training under the supervision of a forensic pathologist certified by the American Board of Pathology or are they themselves so certified?	One Phase I for each unqualified physician	___	___	___
/#3A.7 Is the medical staff of sufficient size that no autopsy physician is required to perform more than 350 autopsies/year?	II	___	___	___
3A.8 Is the medical staff of sufficient size that no autopsy physician is required to perform more than 250 autopsies/year?	I	___	___	___
3A.9 Are all medical staff licensed to practice medicine in all jurisdictions covered by the office?	I	___	___	___
#3A.10 Is the office's chief investigator or is at least one principal investigator credentialed as a Registered Medicolegal Death Investigator by the American Board of Medicolegal Death Investigators?	I	___	___	___
3B TOXICOLOGISTS				
3B.1 Does the chief toxicologist have training and experience in forensic toxicology?	II	___	___	___
3B.2 Does the chief toxicologist hold a doctorate degree from an accredited institution?	I	___	___	___
#3B.3 Is the chief toxicologist certified by the American Board of Forensic Toxicology (ABFT)?	I	___	___	___
3C CONSULTANTS				
3C.1 Is the office affiliated with a forensic anthropologist board certified by the American Board of Forensic Anthropology (ABFA)?	I	___	___	___
3C.2 Is the office affiliated with a forensic odontologist board certified by the American Board of Forensic Odontology (ABFO)?	I	___	___	___
3D MEDICAL INVESTIGATORS				
3D.1 Are there written and implemented qualifications established for medical investigators?	I	___	___	___
3D.2 Have medical investigators received specific training in the policies and procedures of the office?	II	___	___	___

changed 10/29/98
changed 10/15/99
/ changed 9/27/02
} changed 2/18/03

	PHASE	YES	N/A	NO
3E OTHER PERSONNEL				
3E.1 Does the office have written and implemented policies for the qualifications and training necessary for all technical staff (e.g. histotechnologists, radiology technicians, etc.)?	I	___	___	___
4 NOTIFICATION, ACCEPTANCE AND RELEASE				
4.1 Does the office have a written and implemented policies or standard operating procedure, signed within the last two years covering case notification, acceptance and release?	II	___	___	___
4.2 Is there a written and implemented office requirement that deaths falling under the medical examiner's jurisdiction be reported promptly to the medical examiner's office by law enforcement agencies, physicians, hospital personnel, funeral directors or any other person who becomes aware of a reportable case?	II	___	___	___
4.3 Does the medical examiner accept notification from any person who has become aware of a death that might fall under the jurisdiction of the office?	II	___	___	___
4.4 Is at least one published telephone number for the medical examiner's office in telephone books covering the jurisdiction?	II	___	___	___
4.5 Is the phone number staffed 24 hours a day and able to arrange a disposition at all times?	I	___	___	___
4.6 Are greater than 25% of deaths, occurring within the office jurisdiction, reported to the office annually?	I	___	___	___
4.7 Does the medical examiner, if necessary, arrange for a formal pronouncement of death?	I	___	___	___
4.8 Are next-of-kin notified of deaths in a timely fashion?	I	___	___	___
4.9 Is a record maintained of all cases in which jurisdiction was declined?	I	___	___	___
4.10 Is the case reviewed by a medical examiner when jurisdiction is released?	I	___	___	___
4.11 Is there a written and implemented procedure in place to assure the release of the correct body and personal effects to the funeral home?	II	___	___	___
5 INVESTIGATIONS				
5.1 Does the office have a written and implemented policy or standard operating procedure, signed within the last two years covering office investigations?	II	___	___	___
	PHASE	YES	N/A	NO
5.2 Is there a written and implemented office policy requiring a medical examiner or investigator obtain the initial history of the fatal event, ascertain the essential facts and circumstances, elicit any pertinent medical history, and make a record of the names and addresses of any witnesses?	II	___	___	___

	PHASE	YES	N/A	NO
5.3 Is a history of past medical illness and current treatment verified with the attending physician or by review of decedent's medical and emergency treatment records in applicable cases?	II	___	___	___
5.4 Are emergency medical technicians interviewed when it is likely to be of benefit?	I	___	___	___
5.5 Are the run sheets of emergency medical technicians, emergency room records and hospital charts available to the medical examiner in accepted cases?	I	___	___	___
¶5.6 In criminal cases and violent deaths, does the medical examiner have access to and obtain as needed the investigative findings of the police, fire department and other investigative agencies?	II	___	___	___
5A SCENE INVESTIGATIONS				
5A.1 Is there a written and implemented policy for which cases require scene investigations?	II	___	___	___
5A.2 Is a medical examiner or investigator available on a 24-hour basis to respond for a scene investigation?	II	___	___	___
5A.3 Are medical examiner investigation response times recorded and monitored?	I	___	___	___
5A.4 Does the medical examiner or investigator respond to the scene of those cases deemed necessary by the chief medical examiner?	II	___	___	___
5A.5 When a body has been removed from the scene or a person has been removed for treatment, are follow-up scene investigations conducted where appropriate?	I	___	___	___
¶5A.6 Are diagrams or photographs or digital images prepared to clarify essential spatial relationships between the body, its environment and any significant investigative facts, such as blood, evidence, weapons/instruments, etc., where appropriate?	I	___	___	___
¶5A.7 Are significant circumstantial and physical observations noted and recorded regarding the time of death, (including the presence, location, and degree of rigor; the location, fixation and color of postmortem livor; and when indicated the temperature of body and environmental temperature and climatic conditions)?	I	___	___	___

¶ changed 10/29/98
% changed 10/12/01

	PHASE	YES	N/A	NO
6. BODY HANDLING				
6.1 Does the office have a written and implemented policy or standard operating procedure, signed within the last two years covering body transportation and handling?	II	___	___	___
6.2 Does the body transport system reflect due respect for the body and the concerns of families?	II	___	___	___
6.3 Are the stretchers and carts used to move the body sturdy and in good repair and free of sharp edges?	II	___	___	___
6.4 Are body transport vehicles mechanically sound, clean, secure, dignified and private?	II	___	___	___
6.5 Do office body transport vehicles have scheduled maintenance and repair?	I	___	___	___
6.6 Is the interior of body transport vehicles regularly cleaned and disinfected?	II	___	___	___
6.7 Do body handling procedures ensure the integrity of evidence?	II	___	___	___
6.8 Do body handling procedures include precautions for the biohazards associated with body handling?	II	___	___	___
¶6.9 Is there an established system to document and safeguard personal effects?	II	___	___	___
7. POSTMORTEM EXAMINATIONS				
7.1 Does the office have a written and implemented policy or standard operating procedure, signed within the last two years covering postmortem examination procedures?	II	___	___	___
7.2 Is there written documentation of a physical examination of the decedent's unclothed body prepared for every decedent whose body is examined?	II	___	___	___
7.3 Is there a written and implemented policy which specifies the criteria for the determination of when complete autopsies, partial autopsies, or external examinations are to be performed?	I	___	___	___
7.4 Are autopsies performed in greater than 95% of all cases suspected of homicide at the time of death?	II	___	___	___
*7.5 Are autopsies performed in greater than 95% of all cases in which the manner of death is undetermined at the time an autopsy decision is made?	II	___	___	___

* changed 2/10/98
* Some inspector discretion allowed
¶ changed 10/29/98

	PHASE	YES	N/A	NO
7.6 Are the circumstances of death, if known, reviewed prior to autopsy?	II	___	___	___
7.7 Are clothing and personal effects examined and inventoried in all cases brought into the office for postmortem examination?	II	___	___	___
7.8 Does the medical examiner/autopsy physician personally examine all external aspects of the body in advance of dissection?	II	___	___	___
7.9 Is a medical examiner/autopsy physician responsible for the conduct of each postmortem examination, the diagnoses made, the opinions formed, and any subsequent opinion testimony?	II	___	___	___
7.10 Are all autopsy ex-situ dissections personally performed by a medical examiner/autopsy physician?	II	___	___	___
7.11 Is all assistance rendered by pathology assistants, autopsy technicians, dieners, or others without medical training performed in the physical presence of and under the direct supervision of a medical examiner/autopsy physician?	II	___	___	___
7.12 Are written notes taken for each autopsy which could be used as a basis for report generation if dictated tapes become lost or dysfunctional?	I	___	___	___
7.13 Are specimens routinely retained for toxicologic and histologic examination during autopsies?	II	___	___	___
/7.13A Does the office have a written policy or standard operating procedure, implemented and signed within the last two years covering the retention and disposition of organ and tissue specimens taken at autopsy, that addresses whether, or under what circumstances, next-of-kin are to be notified of each retention or disposition?*	II	___	___	___

*NAME recognizes the complexity and sensitivity of this tissue, and acknowledges that either decision-to notify family members, or to avoid intrusion upon a family, is accepted and appropriate in the practice of death investigation.

7.14 Is there a written and implemented office policy which defines when radiographic examinations are to be performed?	I	___	___	___
8. IDENTIFICATION				
8.1 Does the office have a written and implemented policy or standard operating procedure, signed within the last two years covering identification procedures?	II	___	___	___
8.2 Is there a case body numbering system in place for labeling all bodies? / changed 27 September 2002	II	___	___	___

	PHASE	YES	N/A	NO
8.3 Is the method of identification recorded?	II	___	___	___
8.4 Does the office have access to the following for identification of bodies:				
A. fingerprint comparison?	II	___	___	___
B. dental examination?	II	___	___	___
C. body x-rays?	II	___	___	___
D. forensic anthropology?	I	___	___	___
E. forensic serology and DNA analysis?	I	___	___	___
8.5 Prior to disposition of unidentified bodies does the medical examiner's office perform the following tasks in order to permit potential future identification: fingerprint the body; photograph the body; examine and chart the dentition; take x-rays; store specimens for DNA analysis; and register the case with the FBI's National Crime Information Center (NCIC) or other central registry?	II	___	___	___
9. EVIDENCE AND SPECIMEN COLLECTION				
9.1 Does the office have a written and implemented policy or standard operating, signed within the last two years covering evidence collection?	II	___	___	___
9.2 Does the office have a written and implemented policy or standard operating procedure, signed within the last two years covering tissue and body fluid specimen collection?	II	___	___	___
9.3 Does the office have a written and implemented policy or standard operating procedure, signed within the last two years covering evidence and specimen disposition and destruction?	II	___	___	___
9.4 When collected, are autopsy tissue and fluid specimens individually collected; adequately packaged; properly labeled; appropriately preserved; and archived using a consistent and logical specimen numbering system?	II	___	___	___
9.5 Are specimen containers labeled with the date collected; the type of contents; the name of the deceased; the name of the medical examiner; and the case number?	I	___	___	___
* 9.6 Are formalin-fixed or paraffin embedded tissues stored for at least one year in cases in which microscopic slides are not prepared?	I	___	___	___
9.7 Are specimens collected for microbiological evaluation placed into appropriate current transport medium or sterile containers?	II	___	___	___
9.8 Are microbiologic specimens promptly transported to the service laboratory?	I	___	___	___

*changed 2/10/98

	PHASE	YES	N/A	NO
9.9 In cases of suspected sexual contact:				
A. are control hair samples collected from the decedent by plucking a representative number of hairs from various body areas, i.e., scalp and pubic areas?	II	___	___	___
B. is the pubic area lightly combed to obtain loose and foreign hairs, and are native control hairs plucked and packaged separately?	II	___	___	___
C. are swabbing of body orifices obtained and examined for the presence of spermatozoa, the presence of seminal fluid, and DNA and/or serologic markers?	II	___	___	___
9.10 Are bite marks processed according to an established procedure, with the assistance of a forensic odontologist?	I	___	___	___
9.11 Are written and implemented guidelines available for organ and tissue harvest management?	II	___	___	___
9A TOXICOLOGY SPECIMENS				
9A.1 Does the office have a written and implemented policy or standard operating procedure, signed within the last two years for the taking of toxicology specimens?	II	___	___	___
†9A.1.1 Is peripheral blood used for toxicology whenever possible?	I	___	___	___
†9A.1.2 Is the site of collection (peripheral, central (heart/great vessels), dural sinus, chest cavity, subdural hematoma, etc.) Of blood used for toxicology recorded?	I	___	___	___
9A.2 Are specimens for toxicology promptly delivered to the toxicology laboratory or stored in a secure refrigerator or freezer until delivery is effected?	II	___	___	___
9A.3 When toxicology is requested, is the toxicologist made aware of the circumstances surrounding the death and any medications which may have been taken by the decedent?	I	___	___	___
* 9A.4 Are toxicological specimens retained for at least two months in routine cases and 1 year in homicide cases after receipt of report by the medical examiner?	I	___	___	___
9A.5 In cases of delayed death in hospitalized victims, does the office attempt to obtain the earliest available specimen from the hospital when appropriate?	II	___	___	___

*changed 2/10/98
†changed 10/12/01

	PHASE	YES	N/A	NO
9A.6 In deaths associated with the possible inhalation of toxic gases, are airway and lung specimens collected and stored in containers suitable for headspace analysis?	I	___	___	___
9B EVIDENCE COLLECTION FROM SCENES				
9B.1 Are the hands protected in cases of homicides and suspicious deaths to safeguard evidence when indicated?	II	___	___	___
9B.2 Is it the written and implemented policy of the office to take charge of the body and clothing and take charge or is made aware of any evidence on or near the body which may aid in determining the identification of the deceased and the cause and manner of death?	II	___	___	___
9C CHAIN OF CUSTODY				
9C.1 Are forms for chain of custody receipt in use?	II	___	___	___
9C.2 Do chain of custody forms include the case number and/or name; description of the evidence; the persons involved in the transfer; the date and time of change of custodianship; and appropriate signatures?	I	___	___	___
9C.3 Is the medical examiner able to assure the integrity of the chain of custody of evidentiary items, while under his or her control?	II	___	___	___
10. SUPPORT SERVICES				
10.1 Does the office have a written and implemented policy or standard operating procedure, signed within the last two years covering support services?	II	___	___	___
10A PHOTOGRAPHY				
10A.1 Is there a designated staff member responsible for the inventory, care, and maintenance of the photographic equipment and supplies?	I	___	___	___
10A.2 Is an identifying label included in each photograph such that the label does not obscure the identifying features of the decedent; or alternatively, does at least one photograph per set of photographs in a given case include a label to permit post process labeling of film?	II	___	___	___
10A.3 Is at least one identification photograph taken of all bodies brought to the office?	I	___	___	___

	PHASE	YES	N/A	NO
10A.4 Is there photographic documentation of pertinent findings in suspected homicides?	II	___	___	___
10A.5 Does the office generally photographically document pertinent findings?	I	___	___	___
10A.6 Are photographs taken prior to examination or processing of trace evidence, foreign material, blood patterns, and other items important for determining the cause and manner of death or necessary for medicolegal interpretation or presentation?	I	___	___	___
10A.7 Are orientation photographs (photographs of the same area from a distance or with a frame of reference) taken, when close-up photographs are taken?	I	___	___	___
10A.8 Is at least one measurement scale included in close-up photographs, with evidence photographs, and in those cases when no frame of reference is present in the field of view?	II	___	___	___
10A.9 Is an American Board of Forensic Odontology (ABFO) scale included in all bite mark photographs?	I	___	___	___
10A.10 Are all photographs and any negatives labeled and filed in a retrievable manner?	II	___	___	___
10B RADIOLOGY				
10B.1 Does the office have access to radiographic equipment or services?	II	___	___	___
10B.2 Are the quality of radiographs commensurate with the purpose of the x-ray examination?	II	___	___	___
¶10B.3 Is a written schedule of exposures on hand or is there an alternative system in place so as to ensure proper x-ray film exposures.	I	___	___	___
10B.4 Are radiographs labeled with case number and right/left designation on each film?	II	___	___	___
10B.5 Are radiographs filed so as to be readily retrievable?	II	___	___	___
10B.6 When performed in-house, are the x-ray development equipment and reagents routinely maintained according to a set schedule?	II	___	___	___

¶ changed 10/12/01

	PHASE	YES	N/A	NO
10C HISTOLOGY				
10C.1 Does the office have access to histology services?	II	___	___	___
10C.2 Are microscopic slides retained for at least 10 years?	II	___	___	___
10C.3 Are paraffin blocks stored in a cool area and retained for at least five years?	II	___	___	___
10C.4 In addition to routine H&E staining, are special stains available for microorganisms, iron, fat, and connective tissue?	I	___	___	___
10C.5 Are special stains returned with appropriate control slides?	II	___	___	___
10C.6 Is a cryostat available for rapid diagnosis and for fat stains?	I	___	___	___
10C.7 Are microscopic slides prepared, examined and reported in all sudden infant deaths, unexplained deaths, and where necessary to establish a tissue diagnosis?	II	___	___	___
10C.8 Are microscopic findings reported in the case record as a supplement to the narrative gross autopsy?	II	___	___	___
10D TOXICOLOGY				
10D.1 Does the office have access to a forensic toxicology laboratory?	II	___	___	___
¶10D.2 Is the toxicology laboratory in compliance with the guidelines of the Society of Forensic Toxicologists (SOFT), or accredited by the American Board of Forensic Toxicology (ABFT), the College of American Pathologists (CAP), or a state reference laboratory?	I	___	___	___
10D.3 Is testing routinely available for ethanol and volatiles; carbon monoxide; major drugs of abuse; major acidic drugs; and major basic drugs?	II	___	___	___
10D.4 Does the office have access to stat carbon monoxide testing?	I	___	___	___
10D.5 Are tests performed according to written standard operating procedures?	II	___	___	___
10D.6 Does the toxicology laboratory participate in external proficiency testing for drugs of abuse?	II	___	___	___
10D.7 Is there active monitoring of the laboratory for performance improvement and are corrective actions taken when indicated?	II	___	___	___

¶ changed 10/12/01

	PHASE	YES	N/A	NO
10D.8 Are 95% of negative toxicology examinations completed within 30 days of case submission?	II	___	___	___
10D.9 Are 95% of positive toxicology examinations completed within 60 days of case submission?	II	___	___	___
10E CLINICAL CHEMISTRY				
10E.1 Are routine diagnostic clinical chemistry tests available for analysis of postmortem specimens?	II	___	___	___
10E.2 Is the laboratory accredited by the College of the American Pathologists (CAP) or equivalent?	I	___	___	___
10F MICROBIOLOGY				
10F.1 Does the office have microbiology laboratory services available?	II	___	___	___
10F.2 Is the microbiology laboratory accredited by the College of American Pathologists (CAP) or equivalent?	I	___	___	___
10G CRIMINALISTICS/FORENSIC SCIENCE EXAMINATIONS				
10G.1 Are laboratory services available to perform fingerprinting; serologic and/or DNA testing; ballistics; and trace evidence examination?	I	___	___	___
10H CONSULTATIONS				
@10H.1 Does the office arrange for the availability of expert consultants in neuropathology; forensic dentistry/odontology; forensic anthropology; and radiology?	II	___	___	___
10H.2 Are the consultative services convenient, responsive, complete, reliable, reputable, and credible in court?	I	___	___	___
11. REPORTS AND RECORDS				
11.1 Does the office have a written and implemented policy or standard operating procedure, signed within the last two years covering reports and records keeping?	II	___	___	___
11.2 Are records kept in an orderly fashion for easy retrieval of data?	II	___	___	___
11.3 Are the original reports kept under the custody of the office?	II	___	___	___
11.4 Does each report prepared under the authority of the office include the name of the deceased, if known, and the case accession number? @ changed 10/29/98	II	___	___	___
	PHASE	YES	N/A	NO
11.5 Are there forms for initial notification of death; scene investigation; autopsy report; and chain of custody?	II	___	___	___
11.6 Does the office have a procedural method of keeping track of unfinished or overdue case reports?	II	___	___	___

11A INVESTIGATIVE REPORTS				
11A.1 Are records of the initial case investigative contact available on every death reported to the office, whether or not jurisdiction is accepted?	II	___	___	___
11A.2 Is there a routine reporting form to be filled out by death investigators for case acquisition?	II	___	___	___
11A.3 Does the office maintain a log of each official case investigation performed by office investigators?	II	___	___	___
11A.4 Is a written scene investigation report prepared by the office for every scene visited?	II	___	___	___
11A.5 Do investigation reports include, as applicable, the history obtained from investigators and witnesses; past medical history; circumstantial history; scene observations; pertinent body findings; and notations regarding photographs taken and evidence recovered?	II	___	___	___
11A.6 Are investigative reports routinely available to the pathologist prior to the beginning of any autopsy, external examination, or certification of death?	II	___	___	___
11B DEATH CERTIFICATES				
11B.1 Does the office, in certifying the cause and manner of death, conform with the format of the death certificate prescribed by the local authorities?	II	___	___	___
11B.2 Is standardized terminology of recognized disease nomenclature used in the filling out of death certificates?	I	___	___	___
@ 11B.3 Is the death certificate prepared and signed by the autopsy physician, the chief medical examiner, or his or her designee?	II	___	___	___
11C REPORTS OF POSTMORTEM EXAMINATIONS				
11C.1 Is a written narrative autopsy report prepared in every autopsied case?	II	___	___	___
11C.2 Does the autopsy report include a description of external and internal evidence of injury, review of organ systems, listing of diagnoses, and an opinion of the cause and manner of death?	II	___	___	___

@ changed 10/29/98

	PHASE	YES	N/A	NO
11C.3 Does the forensic pathologist sign the autopsy report after it has been transcribed, proofread and corrected?	II	___	___	___
¶11C.4.1 Are 95% of the reports of postmortem examinations completed within two months from the time of autopsy in homicide cases?	II	___	___	___
¶11C.4.1 Are 95% of reports of postmortem examinations completed within three months from the time of autopsy in all cases (homicides excluded, see 11C.4.1)?	II	___	___	___
11C.5 Is the cause and manner of death listed in the autopsy report consistent with that stated on the death certificate?	II	___	___	___
11D CONSULTATION AND LABORATORY REPORTS				
11D.1 Are the reports of consultations and laboratory tests pertinent to determining cause and manner of death (ballistics, trace evidence, etc.) incorporated into the official records of the case whenever such tests are performed?	I	___	___	___
11D.2 Are request forms available for supplemental laboratory and consultative services?	I	___	___	___
11D.3 Are consultations and laboratory tests tracked and monitored by the office for chain of custody; status of completion; expected return time; billing information; and return of residual specimens, as applicable?	I	___	___	___
>11D.4 Does the office have a written and implemented policy or standard operating procedure, signed within the last two years covering organ and tissue donation?	I	___	___	___
11E ANNUAL STATISTICAL REPORT				
@ 11E.1 Does the office annually compile statistical data on:				
A) deaths reported?	I	___	___	___
B) cases accepted?	I	___	___	___
C) manners of death?	I	___	___	___
D) scene visits by medical examiners or medical examiner investigators?	I	___	___	___
E) bodies transported by office or by order of the office?	I	___	___	___
F) external examinations	I	___	___	___
G) complete autopsies?	I	___	___	___
H) partial autopsies?	I	___	___	___
I) hospital autopsies retained under ME jurisdiction?	I	___	___	___
J) cases where toxicology is performed?	I	___	___	___
K) bodies unidentified after examination?	I	___	___	___
L) organ and tissue donations?	I	___	___	___
M) unclaimed bodies?	I	___	___	___
N) exhumations?	I	___	___	___

A maximum of five Phase One deficiencies can be assigned under this item.
@ changed 10/29/98
> changed 2/23/2000
¶ changed 10/12/01

	PHASE	YES	N/A	NO
11E.2 Does the office have a computerized information management system?	I	___	___	___
11E.3 Does the office prepare an annual report tabulating total cases reported, accepted, examined and autopsied, and the major causes of death sorted by each manner of death category?	I	___	___	___
11E.4 Does the office keep a current list of pending cases with unsigned death certificates?	I	___	___	___
11E.5 Does the office maintain a cross index of categories of cause and manner of death for statistical data retrieval?	I	___	___	___
11F RECORDS KEEPING				
11F.1 Are all paper components of the death investigation in a given case filed in the same place, including investigative reports, scene reports, body examinations, supplemental laboratory reports and consultations, and follow-up information?	I	___	___	___
11F.2 Are the original case reports retained under the care, custody, and control of the office?	II	___	___	___
11F.3 Are completed records located in a central record storage area?	II	___	___	___
11F.4 If long term archival records are stored in a location off premises, are they secure and retrievable?	II	___	___	___
11F.5. Do written and implemented guidelines detail the archiving and destruction times for all records?	I	___	___	___
11F.6 Does the office have a written and implemented policy or standard method for filing, to include how, where, and which records are stored?	I	___	___	___
11F.7 Where the office records are computerized, is there backup information available?	II	___	___	___
11G RELEASE OF INFORMATION				
11G.1 Are copies of official reports available to those individuals having a legitimate right to them?	II	___	___	___
11G.2 Is there a written and implemented procedure regarding distribution of records and information?	I	___	___	___
11G.3 Are copies of the applicable law, regulations, guidelines and legal opinions available?	II	___	___	___
11G.4 Does the office have a written and implemented policy regarding media contact?	I	___	___	___

	PHASE	YES	N/A	NO
12. MASS DISASTER PLAN				
12.1 Does the office have a written and implemented mass disaster (multiple fatality) plan signed within the last two years?	II	___	___	___
12.2 Has the plan been promulgated with the participation of jurisdictional law enforcement, fire, and rescue and emergency agencies and hospitals?	I	___	___	___
12.3 Has the office coordinated with surrounding jurisdictions regarding mass disaster planning?	I	___	___	___
12.4 Has the office participated in local or regional mass disaster exercises?	I	___	___	___
13. PERFORMANCE IMPROVEMENT				
13.1 Does the office have a written and implemented policy or standard operating procedure, signed within the last two years covering quality assurance program?	II	___	___	___
13.2 Is the performance improvement program a planned and regularly scheduled activity?	I	___	___	___
13.3 Is the performance improvement program sufficient and adequate to assure the quality of the office or system workproduct?	II	___	___	___
13.4 Is there documentation of corrective action taken for identified deficiencies?	II	___	___	___
13A PROFESSIONAL CREDENTIALS AND PRIVILEGES				
13A.1 Is licensure of the medical staff verified at the time of initial employment?	II	___	___	___
13A.2 Does the chief medical examiner evaluate the performance of each member of the professional staff at least once each year?	I	___	___	___
13B TRAINING AND CONTINUING EDUCATION				
13B.1 Are all new personnel provided information on the written policies of the office during orientation?	II	___	___	___
13B.2 Is each licensed professional employee required to participate in continuing education?	II	___	___	___
13B.3 Is there continuing education available for all medical investigators?	I	___	___	___

	PHASE	YES	N/A	NO
13B.4 Are operators of radiologic equipment properly trained?	I	___	___	___
13B.5 Are all staff members, medical and nonmedical, who perform duties in a training capacity continually supervised and monitored by a qualified practitioner?	II	___	___	___
13B.6 Are the reports produced by staff members in training reviewed and countersigned by the appropriate supervisor?	II	___	___	___
13B.7 If the office has a training program for forensic pathologists, is the program accredited by the American Council for Graduate Medical Education (ACGME)?	I	___	___	___
13C PERFORMANCE EVALUATION AND MONITORING				
13C.1 Do in-house laboratories participate in external proficiency tests?	II	___	___	___
13C.2 Does the medical staff participate in external check samples or proficiency surveys?	I	___	___	___
13C.3 Are staff sign-out conferences regularly scheduled for discussion and disposition of pending and problem cases?	I	___	___	___

Guidelines for the Utilization of Pathology Assistants in Medical Examiner Offices

October 1991

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Abstract

The establishment of non-physician providers in anatomic pathology as active participants in medical examiner's offices has resulted in concerns regarding the supervision and medical practice of pathologists' assistants. Forensic pathologists possess the scientific expertise to investigate sudden and violent deaths. Individuals with varying degrees of training routinely assist the forensic pathologist in many aspects of the medical examiner's office including scene inspection, investigation, and autopsy dissection. The National Association of Medical Examiners in accordance with its *Standards of Inspection and Accreditation* maintains that the performance of an autopsy and other medically related duties are considered the practice of medicine. NAME proposes the following as guidelines for the use of trained pathology assistants in medicolegal death investigation systems.

Introduction

In recent years, changes in the pathology workplace increasingly have incorporated non-physician providers in areas related to modern death investigation such as the performance of autopsies, body examination and scene inspection. Pathologists' assistants (PA) are non-physician graduate level providers in anatomic pathology functioning as dependent practitioners under the direction of anatomic pathologists. The first pathologists' assistant (PA) training program was established in 1969 and accredited by National Accrediting Agency for Clinical Laboratory Services. There are currently five accredited programs in the United States. Their duties typically include examination, dissection and processing of tissue samples and autopsy prosection.[1]

In the United States, forensic pathologists perform the majority of autopsies for medicolegal purposes. The practice of forensic pathology incorporates the death scene investigation, clinical investigation, autopsy inspection and assimilation and synthesis of the facts of the case to arrive at a medical decision. The autopsy is the practice of medicine. A medical examiner is defined as a physician-pathologist with special training in forensic pathology preferably certified in anatomic and forensic pathology by the American Board of Pathology.[2] Only those individuals who possess knowledge of pathophysiology learned through clinical as well as laboratory medicine are capable of making medical decisions and diagnosis at a legal standard. Despite their education and experience, forensic pathologists daily confront medical issues and challenges at the autopsy table, never seen or anticipated, that require the expertise of a trained physician. In addition, in performing the autopsy, the pathologist has a moral obligation to the profession of pathology, the decedent's family and the community at large.

The duties of morgue attendants and lay death investigators are detailed in the *NAME Standards for Accreditation*.[3] These duties generally encompass the acceptance and release of bodies, weight and measures, fingerprinting, removal of clothing and obtaining radiographs. Investigative duties relate to the collection of information, scene investigation and evidence collection.

The pathologist-medical examiner may elect to delegate certain aspects of the scene inspection, investigation or postmortem examination to a non-physician or pathologist's assistant under his/her supervision. However, the pathologist-medical examiner must ultimately assume the responsibility for the investigation of deaths and in particular all aspects relating to the scene, body examination and autopsy under his/her jurisdiction. As contained in the NAME *Standards for Accreditation*, "The pathologist should perform the complete examination, personally observing all findings so that his interpretation may be sound." The complete examination includes inspection of the body externally with and without clothing, making the primary incisions, in vitro inspection of all organs, body cavities, and cranium, removal of the organs from the body and ex situ dissection of the organs. The pathologists take tissue for microscopic examination and interpret all slides.

The pathologist creates all autopsy reports, indicating the role the pathologists' assistant played in the examination.

To exclude pathology assistants totally from participation in medical examiner offices at this time would be both economically impractical and professionally unwise. Pathologist's assistants are currently engaged in a myriad of duties within the medical examiner office and provide essential services. The National Association of Medical Examiners (NAME) therefore presents the following guidelines for the use of trained pathologist's assistants who participate in medical examiner offices. These guidelines do not apply to the activities of dieners, laboratory technicians, mortuary attendants, etc, who have not had formal training and received a degree from an accredited program. These guidelines cover individual pathologists and pathology groups who perform medicolegal autopsies and investigations.

Guidelines for Use of Pathology Assistants in Medico-legal Death Investigations

Qualifications: A pathologist assistant (PA) has received advanced training by an accredited program and is certified by the National Accrediting Agency for Clinical Laboratory Services.

Medical Examiner Office: For the purpose of these guidelines, a medical examiner office is defined as a public agency that is a governmental agency supported by taxpayers and established by law for the investigation of sudden, unexpected or violent deaths.

Duties: The pathologists' assistant (PA) assists the pathologist in the performance of duties related to the inspection, handling, processing and dissection of the body. The following guidelines pertain to the activities of the pathologist assistant.

External Body Examination:

A. Prepares and supplies the autopsy suite for examinations.

B. Adheres to established standards of health and safety with respect to chemical, biological and physical agents established by the various accreditations (CAP, NAME) or governmental agencies (OSHA, NIOSH).

C. Adheres to safety regulations and has received required training in regards to obtaining radiographs.

D. Removes clothing and personal effects under the direction and supervision of the pathologist.

E. Labels containers and specimens for toxicological specimens, trace evidence and tissues under direction of the pathologist. The pathologist maintains the chain of custody.

F. Assists the pathologist, law enforcement officers and/or other criminalist to observe, document, retain, and if appropriate, store evidence.

Autopsy Dissection:

A. Assists with evisceration under the direct guidance of the pathologist. The pathologist must be physically present at the autopsy table where the procedure is performed.

B. Incises the scalp, incises the skull and removes the brain under the direction of the pathologist.

C. Performs additional procedures such as perfusion of lungs, incising of intestine, perfusing coronary arteries and other special procedure under pathologist's supervision.

D. Takes tissue for microscopic examination under the direction of the pathologist.

Release of Information:

A. In regards to the non-medical aspects of death investigation, the pathologist is responsible to communicate all official autopsy findings to the family, law enforcement, media, and attorneys.

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[1] Grzbicki DM, et al., "National Practice Characteristics and Utilization of Pathologists' Assistants," *Arch Pathol Lab Med.*, 2001;125:905-912.

[2] Randall BB, Fierro MF, Froede RC, "Practice Guidelines for Forensic Pathology," *Arch Pathol Lab Med.* 1998;122:1056-1064.

[3] *Inspection and Accreditation Policies and Procedure Manual* (St. Louis, Missouri: National Association of Medical Examiners, 1997).

7. Fragmented care appears to have contributed to the ability of individual physicians to recognize the deterioration in a child's condition. When a child's condition is changing, it is important for the parent(s) to understand the importance of returning to the same assessor and/or facility where the physician can ensure adequate observation and has access to previous records of investigation and/or findings. It is also important that physicians communicate adequately with parent(s) to ensure that they understand what constitutes appropriate follow-up care."

8. The College would recommend that home visits are not appropriate in situations where a child has been seen on multiple occasions for an acute medical illness and whose condition is changing. Home visits do not allow for adequate examination and/or investigation of the condition.

9. The College would support the expansion of Teleradiology and progress on the sharing of information electronically between healthcare facilities to assist in providing optimal care to patients."

The College noted that physicians involved with the care of these children would be notified of the findings. As well, other issues noted would be raised with the appropriate agencies and departments. The CAO supports all the findings and recommendations of the College of Physicians and Surgeons and further, restated one recommendation of the College:

Recommendation CDR.61(99)
That the Government of Saskatchewan ensure that post-mortem examinations of children are performed by pathologists who have expertise in pediatric pathology.

Progress

Saskatchewan Justice responded to this recommendation indicating that it "is currently reviewing its pathology needs in relation to its mandate. This included review of the need for and feasibility of providing various types of pathology services which may assist coroners, police and prosecutions ... your recommendation...will certainly be under consideration by Justice officials."

Need for Integrated Services

1997-1998 Findings

As noted under the section on Suicides, in the 1996-1998 Summary report the CAO recommended that "the DSS, Saskatchewan Health and the Saskatchewan Health Districts (now Saskatchewan Regional Health Authorities) develop a protocol to provide for collaborative case planning for children or youth who are receiving services from both the DSS and a Health District. Further, the CAO recommended that this protocol include a mechanism for review and follow-up to ensure that the needs of the child are being appropriately addressed."

In addition, one of three 1997-1998 child death reviews included in this report indicated a strong need for an integrated case management approach to children and youth who present with complex and multiple needs. The findings and recommendation for this death was not included in the previous Summary Report as the CAO review was awaiting the results of a review by an Intersectoral Committee